DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

July 24, 2019

Re: FOIA Case 2017-05-046

Austin Evers
c/o Sara Creighton
1030 15th Street, NW
Suite B255
Washington, DC 20005

foia@americanoversight.org

**VIA EMAIL**

Dear Mr. Evers:

This is the Department of the Treasury's (Treasury) final response to your Freedom of Information Act (FOIA) request dated May 4, 2017. You seek Treasury records "received by Treasury or exchanged between Treasury and any non-governmental entities related to health care reform," and "all communications, meeting notices, meeting agendas, informational materials, draft legislation, talking points, or other materials received by Treasury or exchanged between Treasury and any state government or state government agency related to health care reform."

There are no fees assessed at this time since allowable charges fell below the threshold for search and duplication.

Your request has been processed under the provisions of the FOIA, 5 U.S.C. § 552. The searches for the documents were completed by November 15, 2017. A review was conducted on 16 responsive documents totaling 54 pages, and sections of one page will be withheld pursuant to Exemption 6 of the FOIA as described below.

**FOIA Exemption 6** exempts from disclosure personnel or medical files and similar files the release of which would cause a clearly unwarranted invasion of personal privacy. This requires a balancing of the public's right to disclosure against the individual's right to privacy. The privacy interests of the individuals in the records you have requested outweigh any minimal public interest in disclosure of the information. Any private interest you may have in that information does not factor into the aforementioned balancing test.

Since Treasury's partial denial response constitutes an adverse action, you have the right to appeal this determination within 90 days from the date of this letter. By filing an appeal, you preserve your rights under FOIA and give the agency a chance to review and reconsider your request and the agency's decision. Your appeal must be in writing, signed by you or your representative, and

should contain the rationale for your appeal. Please also cite the FOIA reference number noted above. Your appeal should be addressed to:

Ryan Law, Deputy Assistant Secretary for Privacy, Transparency and Records
FOIA Appeal
FOIA and Transparency
Privacy, Transparency, and Records
Department of the Treasury
1500 Pennsylvania Ave., N.W.
Washington, D.C. 20220

If you submit your appeal by mail, clearly mark the letter and the envelope with the words "Freedom of Information Act Appeal." Your appeal must be postmarked or electronically transmitted within **90 days** from the date of this letter.

If you would like to discuss this response before filing an appeal to attempt to resolve your dispute without going through the appeals process, you may contact Paul Levitan, the FOIA Public Liaison, for assistance via email at FOIAPL@treasury.gov, or via phone at (202) 622-8098.

A FOIA Public Liaison is a supervisory official to whom FOIA requesters can raise questions or concerns about the agency's FOIA process. FOIA Public Liaisons can explain agency records, suggest agency offices that may have responsive records, provide an estimated date of completion, and discuss how to reformulate and/or reduce the scope of requests in order to minimize fees and expedite processing time.

If you are unable to resolve your FOIA dispute through our FOIA Public Liaison, the Office of Government Information Services (OGIS) also mediates disputes between FOIA requesters and federal agencies as a non-exclusive alternative to litigation. If you wish to contact OGIS, you may contact the agency directly at the following address, emails, fax or telephone numbers:

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Toll free: 1-877-684-6448
Fax: 202-741-5769

Please note that contacting any agency official (including the FOIA analyst, FOIA Requester Service Center, FOIA Public Liaison) and/or OGIS is not an alternative to filing an administrative appeal and does not stop the 90-day appeal clock.

If additional questions arise concerning this action, please contact Samuel Giovannucci at (202) 622-1391; or via email at FOIA@treasury.gov. Please reference FOIA Case 2017-05-046 when inquiring about this request.

Sincerely

Paul Levitan

Digitally signed by Paul Levitan
Date: 2019.07.24 09:07:51 -04'00'

Paul Levitan
Director, FOIA & Transparency

Enclosures:
Original FOIA request
Responsive document set (16 documents)

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Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing.

The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

## KEY HEALTH POLICY ISSUES 2017

The Academy is focused on a broad range of health care issues including:

**Slowing the Growth of Health Care Spending**—How will increasing health care costs affect the affordability of health insurance? Will strategies such as the realignment of provider payment systems, accountable care organizations, and disease management and wellness program initiatives help improve health care quality and contain costs? How would these strategies affect consumers, employers, health plans, health care providers, etc.?

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- Employee Benefits
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American Academy of Actuaries

# Issue Brief

FEBRUARY 2017

## KEY POINTS

High-risk pools could be structured various ways to cover the costs of high-risk enrollees:

- A traditional high-risk pool, in which enrollees are moved into a separately run insurance pool.
- A high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims above a specific threshold is reimbursed.
- A condition-based high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims for enrollees with a given set of conditions is reimbursed.

The impact of adopting a high-risk pool approach on access to coverage, premiums, and government spending depends on the specific approach and how its details are structured, including those related to eligibility criteria, benefit coverage requirements, and funding sources.

It is also important to consider how high-risk pool approaches would interact with other insurance market rules pertaining to insurance issue, benefit coverage requirements, and premium rating.

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## Using High-Risk Pools to Cover High-Risk Enrollees

The distribution of health care spending is skewed, with a small share of the population making up a large share of the spending. As a result, how to provide insurance coverage in the individual market and spread the costs of high-risk individuals is a key public policy question. Under the Affordable Care Act (ACA), individuals with pre-existing conditions are guaranteed that they cannot be denied insurance coverage or charged higher rates based on their health status. Their higher costs are spread across all enrollees. To keep upward pressure on premiums from high-risk enrollment as low as possible, the ACA's individual mandate and premium subsidies were designed to encourage enrollment of lower-cost people, thereby spreading the costs more broadly.

High-risk pools have been suggested as an alternative approach to covering the costs of high-risk individuals in the individual market, and many ACA replacement proposals include high-risk pool provisions. Goals of high-risk pool proposals include providing access to insurance coverage for high-risk enrollees, keeping premiums affordable, and improving stability in the individual market.

This issue brief provides an overview of three potential high-risk pool approaches to covering the costs of high-risk enrollees:

- A traditional high-risk pool, in which enrollees are moved into a separately run insurance pool managed by states or the federal government.
- A high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims above a specific threshold is reimbursed by the high-risk pool.
- A condition-based high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims for enrollees with a given set of conditions is reimbursed by the high-risk pool.

This issue brief provides a brief description of each approach and current examples that use the approach. Because the impact of a high-risk pool program on insurance coverage, premiums, and government spending depends on the details underlying its structure, the issue brief will examine the implications of various design features including eligibility criteria, benefit coverage, funding sources, and regulatory responsibility.

## Traditional High-Risk Pools

Under a traditional high-risk pool, individuals applying for coverage who are high-risk due to pre-existing conditions are segregated from the conventional individual market risk pool and offered coverage in a separate pool. Taking high-risk people out of the conventional market can help keep premiums lower for those remaining in the conventional market. However, the costs for the high-risk pool will be high, necessitating external funding if high-risk pool premiums do not fully reflect the higher costs. Examples of a traditional high-risk pool approach include state high-risk pools prior to the ACA and the ACA's Pre-Existing Condition Insurance Plan (PCIP).

Prior to the ACA, 35 states had high-risk pools for state residents who did not have access to employer coverage or public insurance and who due to pre-existing conditions were either charged much higher premiums for individual market coverage, offered coverage excluding certain conditions, or denied coverage altogether. Some states also used high-risk pools to meet the Health Insurance Portability and Accountability Act (HIPAA) requirement that individuals losing group coverage have access to individual market coverage on a guaranteed basis. The choice of high-risk pool benefit plans was limited, although plan cost-sharing requirements were often similar to ones available in the individual market. Some excluded coverage for pre-existing conditions for six months to a year and, like many individual market plans at the time, coverage was usually subject to lifetime benefit limits. States charged premiums for high-risk pool coverage that were typically capped at 150 percent of the standard premium in their state. In addition to premium income, high-risk pools were supported by a combination of state funds, fees assessed on private health insurance carriers, and, to a lesser extent, federal grants. In 2011, 226,000 individuals were enrolled in state high-risk pools at a total cost of $2.6 billion.[1] The guaranteed availability of individual market coverage at standard rates under the ACA beginning in 2014 reduced the need for

1 National Association of State Comprehensive Health Insurance Plans (NASCHIP), "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012," 26th Edition, September 2012.

**Members of the Individual and Small Group Markets Committee include: Karen Bender, MAAA, ASA, FCA, chairperson; Barbara Klever, MAAA, FSA, vice chairperson; Eric Best, MAAA, FSA; Philip Bieluch, MAAA, FSA, FCA; Joyce Bohl, MAAA, ASA; Frederick Busch, MAAA, FSA; April Choi, MAAA, FSA; Sarkis Daghlian, MAAA, FSA; Richard Diamond, MAAA, FSA; James Drennan, MAAA, FSA, FCA; Scott Fitzpatrick, MAAA, FSA; Beth Fritchen, MAAA, FSA; Rebecca Gorodetsky, MAAA, ASA; Audrey Halvorson, MAAA, FSA; David Hayes, MAAA, FSA; Juan Herrera, MAAA, FSA; Shiraz Jetha, MAAA, CERA, FCIA, FSA; Rachel Killian, MAAA, FSA; Kuanhui Lee, MAAA, ASA; Raymond Len, MAAA, FCA, FSA; Timothy Luedtke, MAAA, FSA; Scott Mack, MAAA, ASA; Barbara Niehus, MAAA, FSA; Donna Novak, MAAA, ASA, FCA; Jason Nowakowski, MAAA, FSA; James O'Connor, MAAA, FSA; Bernard Rabinowitz, MAAA, FSA, FIA, FCIA, CERA; David Shea, MAAA, FSA; Steele Stewart, MAAA, FSA; Martha Stubbs, MAAA, ASA; Karin Swenson-Moore, MAAA, FSA; David Tuomala, MAAA, FSA, FCA; Rod Turner, MAAA, FSA; Cori Uccello, MAAA, FSA, FCA; Dianna Welch, MAAA, FSA, FCA; and Tom Wildsmith, MAAA, FSA.**

state high-risk pools. As of November 2016, most state high-risk pools were either closed entirely or were not enrolling new participants.[2]

To create a bridge to guaranteed issued coverage in 2014, the ACA established the PCIP program, under which state or federally run high-risk pools would be created in every state beginning in 2010. The program was supported by $5 billion of federal funds. To qualify for PCIP coverage, individuals must have been uninsured for at least six months and either have had a pre-existing condition or been denied coverage. Premiums were based on the standard rates for individual market coverage. Total PCIP enrollment grew from 12,000 in 2010 to 56,000 in 2011 to a peak of 115,000 in 2013.[3]

The Kaiser Family Foundation estimates that 27 percent of adults younger than age 65 have pre-existing health conditions that would make it more difficult to obtain coverage if insurers were allowed to medically underwrite.[4] The impact of adopting a high-risk pool approach on access to coverage, premiums, and government spending depends on how the details are structured.

**Eligibility**—The less restrictive the eligibility requirements are for a separate high-risk pool, the higher the high-risk pool enrollment and the larger the premium reduction for those remaining in the individual market. However, higher enrollment also means higher costs for the high-risk pool. Options to determine eligibility include:

- The presence of a specific high-cost medical condition;
- Denial of coverage in a non-guarantee issue individual market;
- Determination that premiums in the individual market are "unaffordable"; and
- Prior coverage or lack of prior coverage requirements.

**Benefit Coverage**—How benefit requirements are set would affect enrollee participation, out-of-pocket costs, overall risk pool spending, and premiums. More comprehensive coverage would provide better access to care and financial protection to enrollees, but would be more expensive. Less comprehensive coverage would be less expensive, but would expose enrollees to higher out-of-pocket costs. Coverage decisions would need to be made regarding:

- Range of benefits covered;
- Cost-sharing requirements;
- Presence or absence of annual and/or lifetime out of pocket limits; and
- Presence or absence of waiting periods for coverage of pre-existing conditions.

**Premiums Charged to Enrollees**—By definition, high-risk pool enrollees are expected to have health costs that far exceed average costs. But high premium rates (and high out-of-pocket costs) can be barriers to enrollment. To keep coverage relatively affordable, premiums can be limited to a specific multiple of standard rates. The lower the premiums, the higher the enrollment, and the more outside funding will be needed. Options for setting premiums include:

- Premium rates set to standard individual market rates or a multiple of individual market standard rates;
- Allow or prohibit third-party payment of premiums; allowing such payments would increase enrollment, but could also increase per-enrollee costs as those payments are typically made on behalf of individuals with especially high health needs;[5] and

2 NASCHP, "State Risk Pool Status Report," November 2016.
3 Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, "State by State Enrollment in the Pre-Existing Condition Insurance Plan," Accessed January 13, 2017.
4 Gary Claxton, et al., "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Foundation, December 12, 2016.
5 CCIIO has raised a concern regarding third-party payments in the ACA individual market. Dialysis providers in particular may be steering patients to ACA plans in order to benefit from higher reimbursement rates. Whether this kind of adverse selection would be a concern for high-risk pools depends on whether the pools are intended to be self-supporting and whether they are meant to be the coverage of last resort.

- Allow or prohibit income-related (or otherwise structured) premium subsidies to be used toward high-risk pool coverage.

**Funding**—If premiums charged to high-risk pool enrollees are limited to below what would be required to cover expected claims and expenses, other funding sources will be required to make up the difference. Incorporating outside funding can spread the costs of enrollees over a larger base. The broader the base of funds, the lower the burden on contributing entities. Funding sources can include:

- Assessments on the private health insurance industry;
- Assessments on self-insured health plans;
- Assessments on providers; and
- Federal or state general revenues.

**Regulation and Administration**—Decisions would need to be made regarding which entities would regulate and administer high-risk pools. They can be regulated and administered at the state and/or federal level. Historically, they were regulated by states, and states differed in their eligibility criteria, funding, etc. Federal rules accompanied both HIPAA and the ACA, which reduced the variation across states to differing degrees. But high-risk pool administration stayed largely at the state level.

**Other Considerations**—A key feature of the traditional approach to high-risk pools is that they are separate from the individual market. This separation can raise additional considerations:

- Premium rates and eligibility criteria for high-risk pools can have a material impact on premium rates in the conventional individual market. Generally, the more individuals in the high-risk pool, the lower the rates in the standard pool. This would enhance the affordability and perhaps enrollment in the standard pool, but would also drive the costs of a high-risk pool higher.
- High-risk pool enrollees know that they have insurance that is separate and perhaps different from coverage in the individual market. Enrollee participation can depend on whether there are extra enrollment burdens and the perceived value of high-risk pool coverage.
- When high-risk pools are separate from the conventional individual market, there may be fewer benefit choices, provider options, choice of insurers (i.e., only one choice), etc. than in the individual market.
- High-risk pool costs will depend on provider payment rates. One strategy for lowering costs is to lower provider payment rates. However, providers may be less willing to treat patients with high-risk pool coverage if payment rates are lower than those in the individual market.
- If high-risk pools are not administered by an insurer or another entity with experience in care management, it may be difficult for state and federal regulatory agencies to ensure that high-risk individuals are provided with adequate care coordination and management activities. The lack of such activities could worsen health care outcomes and result in higher spending.
- High-risk pool enrollment numbers, the length of enrollment, and the impact on premiums in the individual market would depend on the individual market's issue rules. For example, if there are open enrollment periods that allow guaranteed issue enrollment, high-risk pool enrollees could move to the individual market. That could reduce high-risk pool enrollment (and costs). It could also limit the reduction of individual market premiums that would result from having separate high-risk pools, depending on whether premiums in the individual market are allowed to vary by health status. If continuous coverage is required in order for insurance to be issued on a guaranteed basis and time enrolled in a high-risk pool counts toward continuous coverage requirements, high-risk enrollees could similarly shift to individual market coverage.

- When using a separate high-risk pool, the risk of covering high-cost enrollees shifts away from insurers and individuals in the conventional individual market. High-cost individuals may bear more of the risk through higher premiums. They also bear the risk of uncertain or fluctuating external funding, which could affect coverage availability.

## High-Risk Pool Reimbursement—Based on Health Spending

Rather than setting up a separate high-risk pool, another approach is to use high-risk pool funds to reimburse health plans a portion of the costs of their high-cost enrollees. Individuals with pre-existing conditions would remain in the private individual market. Examples of this approach include Medicare Part D's reinsurance program, the ACA's transitional reinsurance program, and recent changes to the ACA risk adjustment program to include high-cost risk pooling.

Under the Medicare Part D reinsurance program, the federal government covers 80 percent of prescription drug spending that exceeds the beneficiary out-of-pocket threshold, with funding mostly from general revenues. Under the ACA, a transitional reinsurance program was in effect from 2014 to 2016. It used contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. During the program's first year, the $10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.[6] Beginning in 2018, the ACA's risk adjustment program, which transfers money among insurers based on the relative risk of their enrollees, is set to be altered to include a high-cost risk pooling component. A high-risk outlier payment that covers 60 percent of an enrollee's costs above $1 million will be included, funded by a percentage of insurer premiums. In other words, the program will continue to transfer funds among insurers, with no additional funding source. Although the risk adjustment program is administered at the state level, the outlier payment transfers will be at the federal level.

The key feature of a high-risk reimbursement approach is that high-cost enrollees are covered in the same market as other enrollees. A reimbursement approach's impact on premiums and government spending depends on several factors, particularly how reimbursements are structured and the source of funding.

**Eligibility**—High-cost enrollees would remain in the same private individual market as other enrollees—the reimbursement process would be invisible to them. Reimbursements to plans would occur when an enrollee's allowed claims exceed a specified threshold. The lower the threshold and the higher the share of costs above the threshold that are reimbursed, the greater the potential to reduce premiums if reimbursements are externally funded.

**Benefit Coverage**—Because high-cost enrollees would remain in the private insurance market, they would have the same benefit options available to other enrollees.

**Premiums Charged to Enrollees**—Because high-cost enrollees would remain in the private insurance market, they would face the same premiums as other similar enrollees. If external funding is provided to cover the costs of the reimbursements, this approach would lower average premiums. If instead reimbursements reflect transfers of funds among insurers, average premiums would be unchanged.

**Funding**—If a high-cost reimbursement program is structured similarly to the change made under the ACA risk adjustment program, no additional funding would be required; funds would transfer among insurers. As noted, however, no reductions to premiums would result.

6 American Academy of Actuaries, *Drivers of 2015 Health Insurance Premium Changes*, June 2014.

The use of external funds would help reduce premiums. As in the traditional high-risk pools above, sources of external funding could include:

- Assessments on the private health insurance industry;
- Assessments on self-insured health plans;
- Assessments on providers; and
- Federal or state general revenues.

Note that under the current premium subsidy structure, the use of external funding would result in premium subsidy savings to the federal government, due to the lower premiums.

**Regulation and Administration**—A high-cost risk reimbursement pool could be structured to be regulated and administered at either the state or federal level. A unified federal reimbursement program would provide more consistent provisions across all states. However, state flexibility in the specific program parameters could be incorporated.

**Other Considerations**

- The use of high-risk pool reimbursement would limit the risk to insurers of high-cost outliers. As a result, insurers could reduce the risk margins incorporated into the premiums. In addition, especially in the case of external funding, the need for commercial stop-loss reinsurance could decline, further decreasing premiums.
- Compared with a traditional high-risk pool approach, under a high-risk pool reimbursement approach, insurers and enrollees in the conventional individual market would bear the risks of uncertain or fluctuating external funding. For instance, the reimbursement parameters could become more or less generous depending on funding. This could cause uncertainty for insurers as they develop premiums and for their enrollees who could see premium fluctuations from year to year.
- Retaining the high-cost insureds in the private market could help avoid the solvency and potential funding issues that may arise with separate high-risk pool programs.
- Using a dollar threshold approach to reimburse plans for high-cost enrollees can cause some inequities among insurers. Insurers that are able to attain lower provider payment rates and provide more care management and cost-effective care may benefit less than plans with higher spending. Similarly, insurers in low-cost areas may benefit less from this approach than insurers in high-cost areas. Considerations could be given to whether adjustments to reflect provider payment rates and regional unit cost differentials would be appropriate and feasible.
- To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold.
- Unlike in a separate risk pool, a reimbursement approach may allow for more continued care coordination and management activities.
- The program would not impact rules that might be developed for any continuous coverage requirements or other rules applying to applicants.

## High-Risk Pool Reimbursement—Based on Health Conditions

Rather than using high-risk pool funds to reimburse plans based on spending exceeding a threshold, reimbursements could be based on an enrollee having one or more specified high-risk conditions. Similar to when insurer eligibility for reimbursements is based on spending exceeding a threshold, this type of approach is a virtual risk pool that is invisible to the enrollee.

An example of this approach is the Alaska Reinsurance Program (ARP), which provides payments to insurers for individual enrollees who have one or more of 33 identified high-risk conditions. The program is administered by the state's risk pool board. Insurers must request that the ARP funded pool reimburse all claims for the individuals identified with these conditions. Premium revenue, pharmacy rebates, and other revenues the insurers collect for these individuals is passed to the ARP high-risk fund. In effect, individuals with high-risk conditions are placed in a virtual risk pool separate from the other pool. For 2017, the ARP is funded through state general revenues. Premera, Alaska's only marketplace insurer, reduced its 2017 premium increase request from over 40 percent to just under 10 percent as a result of the ARP.[7] For 2018, the state received approval for a 1332 waiver that would redirect any savings in federal premium subsidies (due to lower premiums) to the high-risk fund. Oliver Wyman projects that Alaska individual market premiums will be 20 percent lower in 2018 with the ARP than they would be without the ARP.[8]

Another example of this approach is the Arizona Medicaid program, which uses a catastrophic reinsurance program to cover all claims for enrollees with three specified conditions as well as the costs of 13 biological prescription drugs.

Most of the design issues of this approach would be similar to those for basing high-risk pool reimbursement on a threshold of spending.

**Eligibility**—High-cost enrollees would remain in the same private individual market as other enrollees—the reimbursement process would be invisible to them. Reimbursements to plans would occur when an insurer files claims to the risk pool for insured enrollees who have been identified as having one or more specified high-risk conditions. The list of conditions would need to be defined, and the process for identifying enrollees with one or more of the conditions would need to be determined. Ideally, the conditions included would be those that are not susceptible to discretionary diagnostic coding.

If insurers can decide whether to submit claims to the high-risk pool for eligible enrollees, adverse selection against the risk pool could result. For example, adverse selection would result if insurers under this system wait until the end of the year to request reinsurance for those individuals with the identified conditions whose claims are higher than their revenue, rather than requesting reinsurance for all individuals with the conditions. Requiring all insurers to submit claims on all enrollees with the specified conditions eliminates the selection opportunity.

**Benefit Coverage**—Because high-cost enrollees would remain in the private insurance market, they would have the same benefit options available to other enrollees.

**Premiums Charged to Enrollees**—Because high-cost enrollees would remain in the private insurance market, they would face the same premiums as other similar enrollees. If external funding is provided to cover the costs of the reimbursements, this approach would lower average premiums. If instead reimbursements reflect transfers of funds among insurers, average premiums would be unchanged.

**Funding**—If a high-cost reimbursement program is structured similarly to the change made under the ACA risk adjustment program, no additional funding would be required; funds would transfer among insurers. However, no reductions to premiums would result.

7 Premera Blue Cross Blue Shield of Alaska, Premera Blue Cross Files 2017 Individual Health Plan Rates, July 18, 2016.
8 Tammy Tomczyk, et al., Alaska 1332 Waiver Application: Actuarial Analyses and Certification, November 22, 2016.

The use of external funds would help reduce premiums. As with the two previous options, sources of external funding could include:

- Assessments on the private health insurance industry;
- Assessments on self-insured health plans;
- Assessments on providers; and
- Federal or state general revenues.

Note that under the current premium subsidy structure, the use of external funding would result in premium subsidy savings to the federal government, due to the lower premiums.

**Regulation and Administration**—A high-cost risk reimbursement pool could be structured to be regulated and administered at either the state or federal level. A unified federal reimbursement program would provide more consistent provisions across all states. However, state flexibility in the specific program parameters could be incorporated.

**Other Considerations**

- Using specified conditions means that as high-cost health conditions evolve over time, the list would have to be continually updated. This revision would need to be done in a timely manner each year so insurers can update their administrative systems and properly set premiums.
- The use of high-risk pool reimbursement would limit the risk to insurers of high-cost outliers. As a result, insurers could reduce the risk margins incorporated into the premiums. In addition, especially in the case of external funding, the need for commercial stop-loss reinsurance could decline, further decreasing premiums.
- Compared with a traditional high-risk pool approach, under a high-risk pool reimbursement approach, insurers and enrollees in the conventional individual market would bear the risks of uncertain or fluctuating external funding. For instance, the list of conditions could narrow or widen, or reimbursements be prorated. Uncertainty could result for insurers as they develop premiums and for their enrollees who could see premium fluctuations from year to year.
- Retaining the high-cost insureds in the private market could help avoid the solvency and potential funding issues that may arise with separate high-risk pool programs.
- To encourage insurers to manage care for individuals with specified conditions, insurers should have to retain the risk for a portion of claims.
- Unlike in a separate risk pool, a reimbursement approach may allow for more continued care coordination and management activities.
- The program would not impact rules that might be developed for any continuous coverage requirements or other rules applying to applicants.

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**This issue brief describes three potential approaches for using high-risk pools to cover the costs of high-risk enrollees. The impact of adopting a high-risk pool approach on access to coverage, premiums, and government spending depends on the specific approach and how its details are structured, including those related to eligibility criteria, benefit coverage requirements, and funding sources. It is also important to consider how high-risk pool approaches would interact with other insurance market rules pertaining to insurance issue, benefit coverage requirements, and premium rating.**

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American Academy of Actuaries

# Issue Brief

FEBRUARY 2017

## KEY POINTS

- Allowing insurers to sell coverage across state lines has limited potential for premium savings, as premiums would continue to reflect local health care costs.
- Out-of-state insurers could have difficulty developing provider networks and negotiating provider payment discounts.
- Unintended consequences could result if states are given more flexibility regarding benefit requirements or issue and rating rules. Adverse selection would occur, threatening the viability of insurers licensed in states with more restrictive requirements. The ability for high-risk individuals to obtain coverage could be compromised as a result.

## Selling Insurance Across State Lines

Selling health insurance across state lines has been proposed as a way to increase competition in states with few competitors. For instance, in states using the federal marketplace, 21 percent of enrollees have only one participating insurer for 2017.[1] In addition, insurance premiums vary by state, sometimes considerably. Offering more affordable coverage in states with high premiums is another goal of proposals to allow cross-state insurance sales. The impact of allowing such sales on plan insurance availability and affordability depends on how they are regulated and whether other changes are made to insurance market rules.

**Regardless of where an insurer is licensed, premiums would reflect the costs of health care in an individual's state of residence.**

The ability to lower premiums by allowing cross-state sales of insurance is limited, because a key driver of health insurance premiums is local costs of health care. Individuals in a high-cost area would not necessarily enjoy lower premiums by purchasing coverage from an insurer licensed in a low-cost state. Premiums would reflect local health costs, regardless of where coverage is purchased.

1 Caroline F. Pearson, *2017 Open Enrollment Preview*, Avalere, October 25, 2016.

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**Out-of-state insurers, especially small or regional insurers, could have more difficulty developing provider networks and negotiating provider payment discounts.**
In order for insurers to sell across state lines, they must develop provider networks by establishing reimbursement agreements with hospitals and physicians, or by purchasing access to an existing network. Any cost savings resulting from differences in benefit coverage requirements among states can be small compared to cost savings that can be accomplished through negotiating strong provider contracts. Unless they are able to achieve a large enrollment, out-of-state insurers may have difficulty in negotiating with providers. Small insurers, which may be able to achieve significant provider discounts in their local areas, may have particular difficulty achieving such discounts in other states. As a result, they could be at a competitive disadvantage relative to larger insurers and other insurers that may already have a presence in the state. Similarly, health maintenance organizations (HMOs) and other plans that limit out-of-network coverage would have more difficulty establishing in other states.

**Regulatory authority and consumer protection laws would need to be clearly defined.**
Governmental authority for regulating insurers would need to be clearly defined. Often ignored in discussions of selling insurance across state lines are the establishment and regulation of state-level consumer protection laws. These laws vary from requiring network adequacy to appeal processes for denied services. Absent any regulatory clarification, it is likely that no entity will bear the sole responsibility for regulating insurers or ensuring consumer protections. For example, it would be difficult for state regulators to regulate out-of-state provider networks.

**If states are given more flexibility regarding benefit requirements, adverse selection will occur.**
A key to the sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules. Allowing insurers licensed to sell in any particular state to sell insurance under that state's rules in other states could violate that principle. The ACA harmonized many of the rules applying to the individual and small group markets. Although states have mandated benefits to varying degrees, the ACA's essential health benefit (EHB) requirements narrowed the differences in covered benefits across states. In addition, the metal tier actuarial value requirements set a floor for plan generosity. If those rules are relaxed and states are allowed more flexibility, benefit coverage requirements could again vary by state, potentially dramatically. If insurers licensed to operate in a state that permits less generous coverage are allowed to sell across state lines, adverse selection would result. Those insurers would attract the healthier residents of other states, whereas states with more required benefits or a greater floor on benefit generosity would attract less-healthy enrollees. Premiums for insurance licensed in states with the more comprehensive benefit requirements would increase, and the viability of those insurers would be threatened. As a result individuals with health problems could find it more difficult to obtain coverage.

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**If states are given more flexibility regarding issue and rating rules, adverse selection will occur.**

Similar to the adverse selection problems arising if states have flexibility regarding benefit requirements, adverse selection would occur if states have flexibility regarding issue and rating rules. The ACA harmonized issue and rating rules, which previously had varied by state. Medical underwriting, previously allowed in most but not all states, was prohibited by the ACA; insurers can no longer deny coverage or charge higher premiums to individuals with health conditions. The ACA also limited the extent to which premiums could vary by age; prior to the ACA, some states prohibited premium variations by age, whereas others allowed unlimited variations. If insurers are allowed to sell across state lines and states are again given flexibility regarding issue and rating rules, insurers licensed in states with less restrictive rules will attract younger and healthier enrollees, whereas states with more restrictive rules will attract older and less-healthy enrollees. Premiums for insurance licensed in states with the more restrictive rules would increase, and the viability of those insurers would be threatened. As a result, older individuals and those with health problems could find it more difficult to obtain coverage.

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**As high health costs persist, insurance affordability remains a challenge for many employers and individuals. However, allowing insurers to sell coverage across state lines could result in unintended consequences such as market segmentation that could threaten the viability of insurers licensed in states with strict benefit coverage, issue, or rating rules. The ability for high-risk individuals to obtain coverage could be compromised as a result. If rules governing insurance are consistent across the states, as they are under the ACA, market segmentation could be minimized. However, potential premium savings would also be minimal, as premiums would continue to reflect local health care costs, regardless of location of the insurer.**

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American Academy of Actuaries

# Issue Brief

NOVEMBER 2016

## KEY POINTS:

- The increasing growth in state Medicaid budgets due in part to the long-term care (LTC) needs of a growing elderly population combined with the low level of penetration into the potential market by private LTC insurance have prompted a number of proposals for reforms in the way LTC is financed in the United States.
- Proposals for reform of the LTC system to provide access to affordable long-term care for the elderly in the United States need to address the seven essential criteria if the reforms are to be of value and to endure for the long term. Any proposal that fails to do so will yield LTC reforms that are less valuable and less likely to endure.
- Some recent attempts at reforming how long-term care is financed in the United States have failed because they did not adequately consider these seven essential criteria. For example, the CLASS Act enacted as part of the Affordable Care Act—and subsequently repealed—failed to consider at least two of the criteria: Affordability and Financial Soundness and Sustainability.

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# Essential Criteria for Long-Term Care Financing Reform Proposals

## Introduction

The increasing growth in state Medicaid budgets due in part to the long-term care (LTC) needs of a growing elderly population combined with the low level of penetration into the potential market by private LTC insurance, have prompted a number of proposals for reforms in the way LTC is financed in the United States. Proposed reforms can be expected to address both public and private financing mechanisms, as well as mechanisms involving both types of financing.

In 2012, the American Academy of Actuaries hosted a roundtable, "A National Conversation on Long-Term Care Financing," comprised of stakeholders from public policy, actuarial, research, private provider, and retirement benefits backgrounds to discuss potential reforms to the LTC system. Building further upon that conversation, the Academy's LTC Criteria Work Group developed criteria in the following areas that should be considered in any discussion on reform:

1. Coverage (with reference to how many individuals are covered by the reform);
2. Comprehensiveness of benefits;
3. Quality of care;
4. Understandability and choice;
5. Affordability;
6. Risk management and cost control; and
7. Financial soundness and sustainability.

This issue brief offers an overview of each area.

The terms "system," "program," and "plan" are used interchangeably because the criteria are intended to cover reforms using both public and private financing mechanisms, or hybrid combinations. Furthermore, while "participants" and "members" are terms often associated with public and private programs, they are also used interchangeably to reflect the breadth of possible proposed reforms.

## I. Level of Coverage and Attributes

Reform proposals should consider the level and makeup of coverage—how many people are expected to be covered and the attributes of those people. Both the total number of people covered and the attributes of those covered will be affected by whether the LTC system is mandatory or voluntary.

Reform proposals should describe how the LTC system will provide coverage to subsets of the population having different attributes. Subsets of the population will have differing needs for LTC services and differing abilities to pay for such services. Examples of population attributes to consider include:

1. Demographic characteristics, such as age, gender, and marital status;
2. Health status characteristics, such as current general health condition and need for LTC services, and expected future need for LTC services; and
3. Wealth and income characteristics, which could be measured in various ways such as value of assets or lifetime income earned.

Likely the most influential feature driving the number and attributes of people covered under an LTC system is whether it uses a mandatory or voluntary design for providing coverage. Voluntary designs will likely have participation levels below 100 percent, while mandatory designs by definition imply all (or nearly all) individuals are covered under the system. Alternatively, a hybrid system could be constructed that blends features of both. For example, the system may provide a mandatory component that does not cover all expected LTC needs, with an option to purchase additional coverage on a voluntary basis.

The design of voluntary programs should anticipate not only the expected number of people covered but also the mix of individuals by the population attributes noted above, as the attributes of individuals covered will have a large impact on program costs. Proposed voluntary designs should anticipate enrollment counts for the various attribute groups, and clearly define how they will control costs based on that expected mix of individuals. Design elements that can address this risk include:

1. Underwriting to understand potential current and future LTC needs;
2. Vesting periods before benefits can be accessed to address individuals currently needing LTC;
3. Limiting the target population to those with expected lower LTC needs (e.g., those actively working); and
4. Use of active or passive enrollment (i.e., opt-in/opt-out).

Reform proposals should require performance of sensitivity testing and careful consideration of the interaction of expected enrollment mix, expected LTC needs, and revenue needed to cover those LTC costs.

## II. Comprehensiveness of Benefits

Reform proposals should clearly communicate the comprehensiveness of benefits provided by the LTC system—that is, the amount of risk that is covered by the system should be defined clearly, including benefit criteria and benefit limitations. Communicating the comprehensiveness of benefits requires an understanding that the needs of the targeted population vary by geographic regions, as well as transparency in stating the levels and types of

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care being provided. The following concerns should be addressed when determining a proposed reform's level of comprehensiveness. When communicating this comprehensiveness, it is important to understand and communicate how these challenges interact.

1. **Location of Care**—Where can members receive care? This includes, but is not limited to, nursing homes, assisted living facilities, and care given in the home. Proposals should have clear definitions for the locations of care and for the handling of transitions to different care settings. In addition, proposals should be able to address the continually changing manner of providing care in these settings as well as the future evolution of new and innovative care settings. Future care settings may include alternatives to today's typical home and community care systems, such as those that are modeled after Continuing Care Retirement Communities, those that use new types of informal care, and those that use rehabilitation center/ transition care centers, to name a just a few possibilities.

2. **Eligibility of Care**—When is a member's care covered as part of the proposed plan? Common measurements define the severity of an individual's impairment. For example, eligibility may be defined in terms of an inability to perform activities of daily living or an evaluation of cognitive impairment. Eligibility for care provided in certain settings or locations may depend on the nature or degree of an individual's impairment.

3. **Limits of Total Coverage**—What are the overall coverage limits, and how do benefits used under the program count toward these limits? This includes clearly defining when coverage starts, the duration of coverage, and how this program will interact with other programs and/or coverages. Proposals should set forth elimination or waiting periods in the program. The duration of coverage can be defined in terms of a maximum dollar amount or in terms of a maximum period of time.

4. **Limits on the Level of Care Covered**—What are the maximum amounts paid during a specified period of time? Common time periods used for this type of limit have been daily or monthly maximums. Proposals should clearly describe whether the maximums increase with inflation or continue at current levels, and whether they vary by location of care. Proposals should define whether periodic benefits are paid in full or whether the benefits are limited to the actual expenses that the member incurs. Finally, proposals should be clear as to how the benefits are coordinated with other private and public means of payments.

## III. Quality of Care

Like many other aspects of life, people contemplating long-term care should evaluate the costs and the benefits of their choices. Quality of care is an aspect of the benefits they choose, and a good reform will offer (1) an ability to assess or measure the quality of the care, (2) incentives to maintain or improve the quality, and (3) a mechanism to make the consumers and the providers aware of the quality of care.

1. **Quality Measurement and Assessment Framework (Qualitative and Quantitative)**
   A standardized framework is needed to monitor and objectively benchmark the quality of the care. For example, Medicare's rating systems (Five-Star Quality Rating System for nursing homes and Home Health Star Ratings for home health care providers) cover a wide range of metrics and could be used as a benchmark for objective standards for all existing types of providers of care. Also, AARP state scorecards offer an objective measure that could be modified to accommodate provider performance.

   As types of care and providers of care evolve, a quality measurement and assessment framework should be set up to cover all of them, and be flexible to respond as new locations of care and providers emerge.

Quality measurement should cover multiple domains, including patient and family centeredness, transitional care processes, performance outcomes, safety, timeliness, efficiency, equity, and cost-effectiveness. Patient and caregiver surveys could be an additional source of data.

**2. Quality Incentives**

Quality incentives should be considered for the overall industry as well as for individual providers. Though not necessarily an exhaustive list, the key incentive targets might include:

a. The supply of providers in a geographic area (assuming quality depends on adequate supply);
b. Evidence-based caregiver training (e.g., family caregiver support training for cognitively impaired patients);
c. Appropriate location of care within a facility or residence;
d. Appropriate care transition (e.g., reducing re-admission to hospitals);
e. Consumer transparency related to the structure of the care provided, including expected length of care, location of care policies, and what situations the provider of care could accommodate or not (e.g., assisted living facilities may not be able to provide adequate care for severe conditions);
f. Suitability and accountability of the provider of care (e.g., consider whether a family member has the capability, credentials, and training to provide care at home); and
g. Prevention (e.g., fall prevention, safety, wellness management, medication management, and activity level).

**3. Quality Awareness**

Awareness of the quality of care is needed from both a provider and a patient perspective. Awareness can be achieved with initial education, access to and readability of educational resources, and identification of what types of coverage the patient is eligible to receive. Education and educational resources may include information regarding fall prevention, wellness management, medication management, safety features, the availability of services and providers, and services that help the provider and caregiver perform their work well for the long term. Educational resources may also make users aware of other services available, whether charitable, publicly operated, or private.

## IV. Understandability and Choice

Well-designed reforms will recognize that the needs of individuals and families vary widely. Program benefits may be designed to vary in order to accommodate these differences. For example, a reform may offer optional elimination or waiting periods where the offered choices may be intended to vary depending on differences in individual ability to rely on other resources such as assistance from family members, assets and income sources, or public and private programs.

Simpler reform designs may include very basic coverages and eligibility requirements that do not change over time. These designs may limit user choice, but they may also be simpler to understand and easier to administer. However, if the reform is too basic, those managing it may not have the ability to (1) address unique and changing needs of individuals and families over time or (2) address environmental changes that emerge (such as the economy, government budgets, or cultural values).

More complex reform designs may include the flexibility of the reform to adapt over time. However, the more complex the system, the more difficult it may be for the individual user to understand how the effects of the program may change over time. A complex system may be more difficult to administer.

Complex systems may also make the value proposition more difficult to assess. Complexity is introduced when reforms include many choices for individuals. It may be difficult for individuals to understand which choice might be best for them. Alternatively, allowing more choice within a reform may make it easier for individuals to select a program based on knowledge of their own expected emergence of need. Without sufficient education, it could be difficult to prevent individuals from being inadequately or excessively covered, potentially engendering public distaste for the program or poor results if selection against the program occurs.

Whether the reform establishes a simple or complex system/program, some level of education will be necessary as the reform takes effect and throughout the existence of the program. Any educational tools developed should help consumers understand their needs, the benefits provided by the program, and how their use of the program can affect the cost of the program in the future. If consumers are allowed to modify their choices over time, those eligible for the program need to be reminded or re-educated periodically about these choices. Ongoing choices and the need for education may therefore require administrative staff to help users navigate the system throughout the life of the program.

Consumers may also need help in understanding that specific cost-control features in benefit designs are intended to prevent overutilization that could increase consumers' own costs later. They may need assistance in preventing early use of benefits that they could need later.

Finally, when making a choice within the program, consumers should be able to discern their needs, their circumstances, and the availability of assistance. They can only make appropriate selections when benefit limitations are stated clearly, without ambiguity, and when their cognition is not impaired.

## V. Affordability

Affordability varies by level and source of family or individual income, type of coverage, other household expenses, whether the program costs are permitted to change over time, and other factors. Therefore, affordability is a key financial issue for each purchaser. The "purchaser" may be an individual or a family unit. A family unit, frequently having two wage earners, is an important point for consideration because LTC programs could consider the impact of benefits and services on the family unit. Affordability may be usefully described on an after-tax, available-dollars basis including income and assets, both of which will likely change over the life of the purchaser. Households would likely subtract expected amounts spent for necessities such as food, clothing, shelter, transportation, medical care, and prescription drugs. Their remaining funds drive the ability to pay the LTC program contributions, so that the purchaser may ask, "What part of my/our remaining funds would I be willing to give up as a contribution in order to purchase the LTC benefit?"

Purchasers should consider the continuing affordability of the program over their remaining lifetime. Continued affordability will be influenced by the contribution structure of the program. A program could be designed like Medicare Part B or Part D, with increasing premiums that are redetermined annually, or with a levelized premium structure like that of many insurance products. In the case where the purchaser expects to live on a fixed retirement income without inflation adjustment, the affordability of the LTC program may become strained for them if the program is subject to anticipated continual jumps to higher contribution levels (by design), or unanticipated increases (e.g., rate increases on levelized premiums). Programs without guarantees or limits on contributions or benefits will require purchasers to carefully evaluate their answer to the affordability question over the long term, especially in the case of those with fixed retirement income and when the initial participation decision was based on contribution levels near a purchaser's upper bounds of affordability.

## VI. Risk Management and Cost Control

In order for any reform to be sustainable, risk management and cost control elements should be considered. A risk evaluation system should be developed prior to rolling out the program. Cost controls should be established that allow for alignment of interests of all stakeholders. Performance of the program should be evaluated based on the predefined criteria, and cost controls should be modified as needed.

A risk evaluation system may depend on projection models, sensitivity testing, stress testing, and evaluation of emerging risks used to identify, assess, measure, mitigate, and manage various risks faced by the program.[1] Also, these may be useful in designing and

1 An actuary performing this work should refer to the applicable actuarial standards of practice (ASOPs), (such as ASOP No 7, *Analysis of Life, Health or Property/Casualty Insurer Cash Flows;* ASOP No. 18, *Long-Term Care Insurance;* ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations;* and ASOP No. 46, *Risk Evaluation in Enterprise Risk Management.*) An actuary may wish to consult the Applicability Guidelines for more information on which ASOPs may give guidance to them on particular types of assignments.

evaluating risk management and controls in LTC reforms. For example, some programs may depend on sound management of the program's assets and liabilities, and projection models will help direct the managers of the program under expected economic environments and help prepare the managers for corrective actions under adverse situations.

Reforms will need to provide benefits that are perceived to be sufficiently comprehensive while at the same time not encouraging overutilization. To control costs, there will need to be features that limit benefits and unintended utilization. The interests of the users of the program and the financiers of the program should be aligned. Care should be taken so that individuals are not able to profit from using services and are not encouraged to use services that may not be necessary. Possible controls may include reimbursing a portion of actual expenditures, rather than paying a stipulated cash benefit, and by not reimbursing for care provided by family members.

Ongoing risk evaluation and management over the program's lifetime is necessary in order to be able to determine whether the program is performing according to expectations. Before a reform is implemented, a pre-planned feedback mechanism that studies the effectiveness of the reform is important. Any ongoing evaluation of the program used to monitor its known and emerging risks should be designed around the controls and risk evaluation that were initially developed and made available as part of the program so that corrective action can be made to the program over time. Corrective actions or controls might include changing the amount of money paid into the program or limiting or changing the benefit payments or eligibility requirements to receive benefits.

As the program matures and is evaluated over time, it will be affected by more factors than those internal to the design and users of the program. It will also be affected by the changing economy, political environment, and demographics of those covered by and contributing to the program. It is possible that some demographic changes can be predicted more accurately than changes to the economy and the political environment. Whether these changes are predictable or not, various scenarios should be evaluated before implementation so the emerging risks underlying these potential changes can be evaluated and potential controls can be designed so the program can react to any changes in these areas that emerge over time.

Any program that includes long-term projections will require significant assumptions to develop those projections. The assumptions will be developed from available data, and critical judgment will need to be applied to determine when to adjust the assumptions based on emerging experience and the credibility of that experience. An appropriate margin should be applied to the assumptions. An actuary performing this work should refer to the applicable actuarial standards of practice (ASOPs) for guidance.

As part of the initial and ongoing monitoring of a program, clear definitions of relevant statistics are needed; e.g., for such areas as the expected amount of coverage the proposal will provide for the targeted group. For proposals that place limits on the level of coverage, chosen statistics should account for the likely shift in expected use caused by the coverage limits.

## VII. Financial Soundness and Sustainability

A new program's financial soundness and sustainability refers to the ability to deliver what is promised, knowing that these promises extend well into the future. The ability to deliver on promises also includes the new program's interface with other existing programs without disturbing the ability of the existing systems to meet their own commitments. Consideration of the following four key questions will help determine whether a program is financially sound and sustainable.

1. **Can consumers be confident that the program will indeed deliver what was promised?**
   Sound risk management and cost controls give confidence to consumers that the program will deliver on all of its promised future obligations. The funding structure of the program is important. Because the need for LTC increases with age, there is good reason for the sake of program sustainability

to design the program using systematic prefunded pooling of homogenous risks in which participants make substantial contributions during their working years, continue to contribute during their retirement years, and receive most of their benefits in the last few years of life or possibly die without ever needing LTC. A reasonable fear of consumers is the risk that the program runs out of money precisely at the point where the participants are most in need and unable to care for themselves. This risk can be minimized by designing cost controls into the program. Controls may need to change when the market's environment changes over time. For example, if the reform were to restrict initial underwriting on the future cohorts of applicants, resulting in higher-risk participants, the program would need to address the higher risk with a different control to address the changes brought on by the restricted underwriting. Another hypothetical example would be a modification of certain controls due to advances in medicine, such as a cure for Alzheimer's disease.

Alternatively, a pay-as-you-go system makes use of young and healthy participants effectively paying the current costs of the participants receiving benefits. More precisely, costs from the generally older participants in need of LTC can be funded by the contributions of all the participants. This design allows the older members of the first cohort to claim benefits with a lower level of contributions than under the prefunding design.

Another alternative may be a partially prefunded system that attempts to buffer some of the risk of a pay-as-you-go system by accruing sufficient funds to meet established sustainability criteria. However, any program that is not fully prefunded may need to address a changing mix of contributors and benefit users if it is to be sustainable into the future.

2. **Is the program too complex or too simplistic?**
The level of program complexity generally depends on its design. While prefunding and pay-as-you-go systems are considered comparatively simple, a partially prefunded design can be quite complex, as such a system depends on defining the relative size of the prefunding component. Pay-as-you-go or fully prefunded programs may become more complex if they are likely to evolve into a partially prefunded design over time. For example, a program that is characterized as prefunded but is projected to run out of funds in, say, 75 years, would be properly described as being only partially prefunded. Programs having changing mixes of prefunding and pay-as-you-go could be complex. Other design considerations that influence the complexity of any insurance-based program include benefit triggers, definition of qualified locations of care, elimination period definitions, and many other product-specific options. The amount of choice provided to participants complicates accurate forecasting of the level of future benefits, and an assessment of the program's sustainability may be affected by the ability (or inability) to reasonably predict future benefits resulting from their choices.

3. **Does the financial program make appropriate use of the funds invested?**
Sound investing of the program funds enhances the performance of the program, which is particularly important for programs that have an appreciable degree of prefunding. Choices for investments will depend on whether the program is private or public, with greater restrictions likely on the options for public programs (based on observation historically of public programs). The options for private programs, absent regulatory restriction, allow greater flexibility in investment options, which means that the trade-off between risk and return becomes a more important consideration when evaluating financial soundness and sustainability of the program.

4. **Can the designers ensure that the program interacts well with existing private insurance and public programs?**
Part of the complexity of designing a new LTC program is that there is currently in place a patchwork of existing programs. Public programs, including Medicaid, Medicare, and

those administered by the Veterans Health Administration, and others jointly cover close to two-thirds[2] of the cost of formal LTC services being provided today. These programs combine with existing inforce insurance coverage provided by private LTC insurers and include a small percentage of "public/private partnership" policies. Thus, critical questions come into play: How is any new program to interact with these existing public and private programs? Is the new program intended to displace all or part of the existing programs? Is the new program intended to provide coverage to persons not currently covered by any existing program? How do definitions of a qualifying event vary between programs? Are participants in existing programs penalized by the reform?

## Conclusion

Some recent attempts at reforming how long-term care is financed in the United States have failed because they did not adequately consider these seven essential criteria. For example, the CLASS Act[3] enacted as part of the Affordable Care Act—and subsequently repealed—failed to consider at least two of the criteria: Affordability and Financial Soundness and Sustainability.

This issue brief identifies and discusses the seven essential criteria for LTC reform proposals: Coverage, Comprehensiveness of Benefits, Quality of Care, Understandability and Choice, Affordability, Risk Management and Cost Control, and Financial Soundness and Sustainability. Proposals for reform of the LTC system to provide access to affordable long-term care for the elderly in the United States need to address the seven essential criteria if the reforms are to be of value and to endure for the long term. Conversely, any proposal that fails to do so will yield LTC reforms that are less valuable and less likely to endure.

Furthermore, the criteria often rely on three activities: adequate education of the consumer, awareness of any alignment or misalignment between the interests of consumers in the program and the interests of those financing the program, and, from an actuarial perspective, sensitivity testing (testing the impact of alternative assumptions). When a proposed reform's conformity to the seven essential criteria is evaluated, these activities will be useful in helping the reform to achieve the ultimate goal of providing necessary and adequate care to the elderly in the population.

The American Academy of Actuaries has unique expertise to advise and assist public policymakers with aspects of these criteria related to risk and financial security issues.

2 *The Long-Term Care Financing Crisis*, by Diane R. Calmus. Center for Policy Innovation; Feb. 6, 2013.
3 Community Living Assistance Services and Supports (CLASS) program.

American Academy of Actuaries

# Issue Brief

JUNE 2016

## KEY POINTS:

Private LTCI is complex—a policyholder is essentially paying today for a varied range of care he or she may or may not need years, if not decades, into the future.

Insurers are gradually learning through their claims experience what the actual levels of benefits are and will be.

A means for taking corrective action to accommodate the changing future is important.

# Understanding Premium Rate Increases on Private Long-Term Care Insurance Policyholders

America faces a great public need in addressing long-term care (LTC) financing, and that need is growing even more critical because the population is aging. There can be substantial costs for LTC services and supports, and for elderly Americans and their families, finding ways to pay for those services and supports can be challenging. According to the U.S. Department of Health and Human Services, about half of Americans turning 65 today will need LTC; one in seven adults will need care for more than five years; and one in six will spend at least $100,000 for future LTC.[1]

Private LTC insurance (LTCI) is an option for financing future LTC needs; however, it is often considered cost-prohibitive by many potential consumers. In particular, in recent years, LTC[2,3] has gotten a lot of attention because of the relative size and frequency of premium rate increases. The American Academy of Actuaries' Long-Term Care Reform Subcommittee has developed this issue brief to enhance understanding of what is leading to significant rate increases, examine how the need for a rate increase is determined, discuss the effects of increases on various stakeholders, and explore alternatives to premium rate increases.

1 *Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief*, Office of the Assistant Secretary for Planning and Evaluation; U.S. Department of Health and Human Services, February 2015.

2 Many LTCI policies include a "guaranteed renewable" contractual provision requiring an insurance company to offer to renew these policies, but the insurance company may do so with a premium rate increase only on a class basis.

3 Some states include short-term care insurance (which generally provides similar coverage to LTC, but for shorter benefit periods, typically for a year or less) under the classification of long-term care insurance. For clarity, this issue brief is not intended to address such short-term care insurance.

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## Factors Affecting LTCI Premium Increases

Private LTCI is complex—a policyholder is essentially paying today for a varied range of care he or she may or may not need years, if not decades, into the future. As such, LTCI requires a long projection period, with some policyholders receiving benefits beyond age 100. Therefore even for the average issue age of 57, policy projections require assumptions for more than 50 years into the future. The future period is even longer for younger policyholders. Further, calculating premiums relies on a number of assumptions for variables such as:

- mortality;
- voluntary lapses;
- interest rates; and
- morbidity, including
  - incidence of disabilities requiring LTC services;
  - recoveries and mortality while on claim;
  - benefit expiry;
  - service inflation costs of covered services relative to inflation protection assumptions; and
  - the amount of services required while disabled (for policies that reimburse actual expenses).

In addition, there has been and continues to be a high level of uncertainty and change in circumstances that affect the level of sufficient premium rates, such as:

- changing pattern of service/care providers (e.g., growth of assisted living facilities and continuing care retirement communities, access to home care services that are covered by LTCI);
- changing medical practice (e.g., criteria for diagnosis of Alzheimer's disease and other cognitive impairments);
- effects of mortality improvement in the population, leading to more older age benefits and longer stays for a given age;
- changes in family composition and availability of caregivers, leading to fewer supports for care at home;
- lower investment income, a crucial consideration for a financial instrument that must accumulate large reserves over many decades to prefund the high cost of services that occur at advanced ages; and
- limited available data under existing LTCI coverage beyond 20 policy years for advanced ages, where morbidity tends to be substantially different from general population data due to the characteristics of those who purchase insurance.

If not for the ability to adjust premiums to better reflect actual experience, carriers would not have offered this type of insurance product. Without LTCI, many more people would exhaust their savings on care costs and then rely on public programs such as Medicaid for their additional care needs.

Often, examining adverse experience from older policy form blocks provides valuable insights that may be applicable to newer blocks. After reviewing the adverse experience, insurers may need to change projection assumptions used for the newer policy forms. The revised projections could identify a need for a premium rate increase. It is important to note that even though adverse experience has not developed yet for a newer block, the revised expected future benefits may be higher for that newer block than previously expected. Recognizing the need to fund the higher expected future benefits for the newer block comes in the form of a premium rate

Members of the Long-Term Care Reform Subcommittee include: P.J. Eric Stallard, MAAA, ASA, FCA, chairperson; Bruce Stahl, MAAA, ASA, vice chairperson; Mark Billingsley, MAAA, FSA; Dave Bond, MAAA, FCA, FSA; Michael A. Boot, MAAA, FSA; Malcolm A. Cheung, MAAA, FSA; Steve Clayburn, MAAA, FSA; Robert W. Darnell, MAAA, ASA; Jim Glickman, MAAA, FSA, FCA; Timothy D. Gustafson, MAAA, FSA; Clark Heitkamp, MAAA, FSA; David E. Kerr, MAAA, ASA; Perry Kupferman, MAAA, FSA; Brad S. Linder, MAAA, ASA; Jamala Murray, MAAA, FSA; David Plumb, MAAA, FSA; Larry Rubin, MAAA, FSA, FCA, CERA; Zenaida Samaniego, MAAA, FSA; Steven W. Schoonveld, MAAA, FSA; Sara Teppema, MAAA, FCA, FSA; Gordon Trapnell, MAAA, FSA; Matthew Winegar, MAAA, FSA; and Ali Zaker-Shahrak, MAAA, FSA.

increase. Actuaries will then communicate the amount of premium rate increases along with their assumed implementation timing to state insurance departments. Both the increase and its associated implementation timing are very important. Deferring implementation of a needed rate increase is detrimental because waiting to implement the rate increase will not start the accumulation of the needed increased premium to fund the higher expected benefits, resulting in the need for a further increase. The effect on consumers is that deferrals generally lead to the need for a higher rate increase than originally calculated.

When original LTCI policy forms were issued in the 1980s and '90s, often morbidity assumptions were based upon general population statistics, and lapse and mortality assumptions upon experience of non-LTC insurance products. Not only did the insured population behave differently than the general population, but improvements in medical diagnostic practices and services and a large increase in the use of assisted living facilities helped increase (1) the number of individuals surviving to ages where the levels of disability are higher, leading to higher claim rates per insured; and (2) the survival time following the onset of disability.

Insurers are gradually learning through their claims experience what the actual levels of benefits are and will be; nonetheless, they still do not yet have a complete basis for assessing the ultimate levels of claims to be paid at advanced ages and later policy durations, nor how these levels might change over time. Insurers will continue to use existing information to estimate these ultimate claim levels and may need to raise premium rates further as more insured life experience develops or if there are unfavorable changes in benefit usage in the future.

## Differences Between Current and Past LTCI Policies

There are significant differences in the pricing characteristics for LTCI policies issued in the past, especially more than a decade ago, compared to policies being issued today and what is expected going forward. The possibility of a future rate increase, at any point in time, is a function of the confidence level in the underlying assumptions and risks associated with these assumptions. With more conservative assumptions, more data to support those assumptions, key assumptions approaching their absolute limits (e.g., ultimate lapse rates approaching zero), and higher explicit margins, it is likely that the probability of rate increases on the current generation of LTCI policies will be lower than the probability of rate increases on previous generations. Future changes in the underlying morbidity, mortality, policyholder behavior, provider behavior, or regulations could alter this likelihood, yet statistical analyses on the experience are helpful when applying historical results to future projections.

A recent presentation[4] of the likelihood of future rate increases on policies issued in 2014 versus policies issued in 2007 and 2000, based on a survey of insurers writing business in 2000, 2007, and 2014, found the following:

- Barring the potential changes mentioned above, and using the same projection model for each time period, the risk of a future rate increase issued in 2014 (using 2014 assumptions) is only one-quarter that of the risk on business issued in 2000 (using 2000 assumptions), and only one-third that of the risk on business issued in 2007 (using 2007 assumptions).
- The primary reasons for this improved expectation of future premium stability are the substantially greater insured experience behind each successive set of assumptions, the significantly lower future downside risk of most assumptions, and an increase in the margins for adverse experience.

4 Stephen Douglas Forman, James M. Glickman, and Roger Loomis, "LTCI New Business Pricing - How Safe Is It?," Society of Actuaries Annual Meeting, October 11-14, 2015.

- Amount of data increased 16-fold from 2000 to 2014.
- Claims data for ultimate experience (e.g., durations 10 and beyond) at attained ages over 80 increased 70-fold from 2000 to 2014.
- Ultimate voluntary lapse rate assumptions decreased from 2.8 percent in 2000 to 0.7 percent in 2014. This leaves very little room for future adverse deviations from lower voluntary lapse rates.
- Best estimate ultimate claim costs in the year 2000 were estimated at 70 percent of the recently released 2000-2011 SOA LTC Experience Study.[5] The corresponding best estimate ultimate claim costs used for 2014 pricing were 108 percent of that SOA LTC Experience Study.
- Ultimate mortality being used in 2014 pricing is 72 percent of the mortality assumption used in 2000.
- Investment portfolio rates were assumed to be 6.4 percent for every future year of a policy issued in 2000, while they are now assumed to be 4.6 percent for every future year of a policy issued in 2014.

• As a consequence of the above, the average policy premiums (for the same benefits) increased to 215 percent of the year 2000 premiums by 2014.

## Determining the Need for Premium Rate Increases

In determining whether LTCI policies require a premium rate increase, two authorized methods are applied—one for policies subject to minimum loss ratio certifications and one for a rate stability certifications.

Historically, LTCI pricing was subject to a 60 percent minimum loss ratio (MLR) by most states, meaning that the ratio of the present value of lifetime claims to premiums could not fall below 60 percent. Beginning in the early 2000s, many states enacted rate stability laws, which stated that LTCI should be priced without using the MLR approach. Instead actuaries would need to certify that the premium rates had enough margin to withstand moderately adverse experience (MAE).

Under the MLR approach, if an insurer demonstrates that revised historical and future projected experience produces a lifetime loss ratio greater than 60 percent (or the originally priced-for loss ratio), a premium rate increase could be filed that would allow the projected experience on the policies to return to that lifetime loss ratio.

Under the rate stabilization approach, a premium rate increase could be requested if actual past experience combined with projected future experience exceeds the original or previously defined MAE margin. If revised projections using updated experience exceed the MAE margin, then a premium rate increase could be filed such that the lifetime loss ratio on the original premiums is assumed to be the greater of 58 percent and the original assumed loss ratio; and the lifetime loss ratio on the increased premiums is at least 85 percent (with claims projected into the future including MAE). For this premium rate increase filing, the amount of premium rate increase needs to be large enough for the insurer's designated actuary to certify that the premiums are sufficient with no further premium rate increases in the future unless the actual experience exceeds a revised MAE margin.

5 Society of Actuaries, *Long Term Care Intercompany Experience Study – Aggregate Database 2000-2011 Report*, January 2015.

Under either approach, the need for a premium rate increase should be driven by projected lifetime loss ratios also, rather than actual past experience alone. Despite the relatively straightforward mathematical calculations to determine premium increases, determining projection assumptions (e.g., whether actual historical experience is sufficiently credible to justify changes in future projected assumptions) can be difficult.

Some assumptions have a higher degree of credibility earlier in the life of a policy than others. For example, policy lapses are more likely to occur in the earlier years of the policy, and claim submissions are more likely to occur in later policy years. As such, actual lapse experience develops a higher degree of credibility in the earlier years of the business while actual claim experience has a lower degree of credibility in the earlier years of the business.

With LTCI it can take a long time from the purchase of a policy until the first time a claim is submitted, and this time period can be several decades for many individual policies. As such, there is often little claims experience to justify premium rate increases on a relatively young group of policy forms based on the experience of those forms alone. Section 3.2.1 of Actuarial Standard of Practice No. 18, *Long-Term Care Insurance*, requires actuaries to use alternative data sources such as public data or experience from the insurance company's older, similar policy forms for identifying reasonable assumptions.[6] Waiting until there is adequate claim information on each policy form could result in much larger, less affordable rate increases.

## Filing and Approval Process

The rate increase process can vary across state jurisdictions, and can be time-consuming. While a company prepares the same initial rate increase filing in each jurisdiction, the filings are addressed differently by many states. Each state/jurisdiction approval includes unique conditions. Approvals are often for different amounts, which sometimes may not be at an adequate level as determined by the company, with different administrative implementation rules and time frames for that approval to be effective.

Larger rate increase requests may experience delays in approval within a state, and depending on the time taken in the approval process might mean the insurer does not receive approval in the year filed, and for that missed year will need to be made up in later years, in the form of an even higher premium rate for that state. Similarly, if a state approves less than the needed increase, carriers will likely request additional increases to make up for the expected shortfall. Thus, the cumulative amount of the increase could be larger than the original request in that state.

It would be necessary to develop steps to improve the filing and approval process that consider regulatory requirements found in state laws and regulations, including:

- An insurer's thorough review signed by an actuary with LTCI experience identifying deterioration and migration from each of the initial pricing assumptions;
- Predesigned rules or guidelines for increase approval that take into account the necessary total increase or an implementation plan for a series of preferred rate increases;

6 Actuarial Standards Board, Actuarial Standard of Practice No. 18, *Long-Term Care Insurance*, January 1999.

- Preset benefit reduction options that will be offered to policyholders in their effort to maintain the same premium level;
- Standardized dates and methods of implementing the rate increases nationally; and
- Seeking greater ability through enhanced standards at the Interstate Compact for premium rate increase approvals.[7]

## The Effects of Premium Rate Increases

LTCI premium rate increases may not align the premiums with the future benefits as well as one might otherwise expect because individual behavior may not align with predictions. There are several reasons for this.

First, an insurer may offer an opportunity to reduce benefits in order to keep the premium dollars a policyholder pays roughly equivalent after the premium rate increase versus before (e.g., reducing the daily maximum benefit). When offered, policyholders may select benefits that better match their current/anticipated health care needs. For example, many policyholders are in the position where they have higher maximum daily benefits than actual current cost of services because the policyholders originally purchased inflation coverage[8] to meet expected inflation needs but actual inflation turned out to be lower. A policyholder who has coverage limits significantly higher than the actual cost of LTC services may reduce their daily maximum coverage such that the premiums do not change and the new maximum benefit levels continue to remain higher than the actual cost of services. Similar examples may exist for lapsing of particular riders or other benefit options.

Second, many states' regulations require that a nonforfeiture benefit be given in lieu of lapse to those who cease paying premiums and whose cumulative premium rate increases exceed a specific percentage based on the issue age of the policyholder. The nonforfeiture benefit is a paid-up benefit with a total policy limit that equals the premiums paid to date (less any claims paid), and payable according to the benefits of the policy had it not ceased to be premium-paying upon implementation of a premium rate increase. The insurer maintains a reserve for these remaining paid-up benefits. While this remaining nonforfeiture reserve is lower, the company will have a harder time monitoring residual benefits in cases in which there is a significant reduction in policyholder contact and no incentive to report an insured's death.

Finally, the policyholders who choose to lapse their policies or reduce their benefits may be the healthier policyholders, leaving the remaining pool of policyholders with higher average expected claims. Ideally, and to the extent the experience is credible, the morbidity experience following a premium rate increase should be compared to the morbidity of similar policies without a premium rate increase.

## Alternatives to a Premium Rate Increase

Insurers have routinely allowed insureds to reduce coverage by changing typical benefit options in order to help offset some or all of a rate increase. In recent years, in an effort to enable policyholders faced with a rate increase to retain significant coverage, some companies have started making available an option for policyholders to avoid the rate increase and keep their same premium by reducing the size of the future benefit increases for plans with automatic built-in inflation increases.

For example, policyholders would be able to keep their accrued benefit at their current inflation rate and only the future increases are lower

7 The Interstate Insurance Product Regulation Compact allows member states to establish standards for long-term care insurance, among other insurance products. These insurance products are governed by the Interstate Insurance Product Regulation Commission (IIPRC), where there is a limited ability to control rate increases through reviews of rate filing standards.

8 A popular inflation option selected by policyholders was the 5 percent option because states required LTC applicants to sign that they rejected this option, which often led to applicants selecting the 5 percent option. This inflation option turned out to be higher than actual LTC cost increases, leaving many policyholders with more coverage than needed.

than they would otherwise be. This is most effective as a conservation tool if it is done on an actuarially equivalent basis, meaning that the new prospective inflation accrual is set so that the present value of the expected reduction in benefits over time will be equal to the present value of the premium increase that is forgone. This is in contrast with most benefit reductions, which are in essence "partial surrenders" where there may be a reduction in the insurer's liability.

When insureds reduce their benefits to help offset a rate increase, an insurer would expect some adverse selection—meaning that the healthier insureds are the ones reducing their benefits and thus the experience on the block will likely worsen over time. With the approach described above, there may be less adverse selection involved because the benefit reductions are gradual and may not become significant for many years.

In the past relatively few insureds have chosen to lapse their policies when premiums were increased and alternatives to the increase were offered. According to a 2010 report from Gen Re (a reinsurance company) based on an industry survey, lapses at the time of a rate increase were only higher than normal by 2.5 percent of the total policies exposed to an increase.[9] The low 2.5 percent extra lapse rate suggests that the increases were generally affordable for the vast majority of policyholders, which is likely due to LTC insurance purchasers being in the higher income and asset demographics than non-purchasers.

## Conclusion

Predicting future policyholder and service provider behavior can be difficult. A means for taking corrective action to accommodate the changing future is important. The more conservative assumptions in today's pricing of private LTCI and improved speed at taking corrective action should improve future projections, resulting in fewer and smaller rate increases.

9 The context for the premium rate increases at the time of the survey included: a low-interest-rate environment, generally lower-than-anticipated lapses and mortality, an average rate increase of about 25 percent in the survey, and premium price points that were generally at or below what policyholders could purchase at their attained ages.

American Academy of Actuaries

# Issue Brief

FEBRUARY 2017

## KEY POINTS

- Expanding the use of association health plans (AHPs) could result in market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage.
- To avoid increased solvency risk, AHPs would need clearly defined regulatory authority and solvency requirements.
- AHPs would need to be subject to state-level consumer protection laws.

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## Association Health Plans

Some proposals put forward to modify or repeal the Affordable Care Act (ACA) would expand the ability of small employer groups and individuals to band together to obtain health insurance through association health plans (AHPs). Proponents of such an approach point out that one of the biggest obstacles to employers offering coverage and individuals obtaining coverage is cost, and argue that AHPs would expand access and drive down costs. The success and practicality of such an approach for increasing coverage options and reducing premiums would depend on how the rules governing AHPs were written.

### AHPs could create adverse selection concerns if they operate under different rules.

A key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules. Although AHPs would be offered in competition with other small group and individual market plans, they could operate under different rules. In particular, if an AHP is allowed to follow the issue, rating, and benefit rules of a single state nationwide, or be pre-empted from state regulation by being self-insured, it would impose different rules on insurance providers offering coverage in the same market. The viability of many state-based markets would be challenged as a result. For example, if an AHP establishes itself in a state with fewer coverage requirements and less restrictive issue and rating rules relative to other states, the AHP would be allowed to use that state's requirements in all states, even those with greater regulatory requirements. Non-AHP insurance plans, however, would continue to be subject to each state's requirements. Such a development would fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain in traditional insurance plans. Such adverse selection would result in higher premiums in the non-AHP plans. Ultimately, higher-cost individuals and small groups would find it more difficult to obtain coverage.

If the rules governing AHPs were consistent with those governing non-AHPs, there would be fewer concerns about market fragmentation. The ACA made many of the rules applying to the individual and small-group markets uniform with each other and nationwide, decreasing the threat of adverse selection and also reducing any cost advantages of AHPs. If the encouragement of AHPs were coupled with an increased flexibility for states to change their issue, rating, and benefit requirements as some have proposed, however, AHPs would raise adverse selection concerns and threaten the viability of the individual market in states with more restrictive rules. Similarly, allowing AHPs to avoid state regulation by self-insuring would result in market fragmentation and threaten the viability of the insured market.

**AHPs face increased insolvency risk without clearly defined regulatory authority.**
Governmental authority for regulating AHPs would need to be clearly defined. Absent this clarification, it is likely that no entity will bear the sole responsibility for regulating AHPs, or that there will be conflicting regulation. The history of multiple employer welfare arrangements (MEWAs) is instructive. Self-funded MEWAs had no clear regulatory authority, as initially it appeared that ERISA exempted them from state-level regulatory oversight. Multiple MEWA bankruptcies resulted, and consumers had limited avenue for redress. Eventually, the federal government issued a written clarification of earlier amendments to ERISA that made it clear that states do have regulatory authority over MEWAs. If regulatory authority for AHPs is not clearly specified, they could suffer the same fate as MEWAs, leaving millions without health coverage due to insolvencies. Surplus requirements for self-funded AHPs should be similar to the minimum requirements for health risk-based capital developed by the National Association of Insurance Commissioners.

**AHPs would need to be subject to state-level consumer protection laws.**
It is important to recognize the need for AHPs to abide by state-level consumer protection laws, which vary from requiring network adequacy to appeal processes for denied services. While AHPs may save money if they do not have to bear the costs of these consumer protections, AHP enrollees may not realize they lack these protections until the time of claim, when it is often too late for recourse.

**AHPs would be unlikely to obtain lower provider payment rates than larger insurance companies.**
It is unlikely that any AHP would be able to achieve the critical mass of enrollees needed to negotiate the deep provider discounts that large health maintenance organizations (HMOs) and insurance companies currently obtain. A more realistic scenario is one in which AHPs "rent" provider networks and pay access fees that depend in part on market leverage and savings. Some of these networks are owned by HMOs and insurance companies that rent out their networks to smaller competitors.

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**As high health care costs persist, insurance affordability remains a challenge for many employers and individuals. However, AHPs could result in unintended consequences such as market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage, AHP insolvencies if they are not subject to clear regulatory authority and solvency requirements, and lack of consumer protections if AHPs are not subject to state-level protections.**

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Members of the Individual and Small Group Markets Committee include: Karen Bender, MAAA, ASA, FCA, chairperson; Barbara Klever, MAAA, FSA, vice chairperson; Eric Best, MAAA, FSA; Philip Bieluch, MAAA, FSA, FCA; Joyce Bohl, MAAA, ASA; Frederick Busch, MAAA, FSA; April Choi, MAAA, FSA; Sarkis Daghlian, MAAA, FSA; Richard Diamond, MAAA, FSA; James Drennan, MAAA, FSA, FCA; Scott Fitzpatrick, MAAA, FSA; Beth Fritchen, MAAA, FSA; Rebecca Gorodetsky, MAAA, ASA; Audrey Halvorson, MAAA, FSA; David Hayes, MAAA, FSA; Juan Herrera, MAAA, FSA; Shiraz Jetha, MAAA, CERA, FCIA, FSA; Rachel Killian, MAAA, FSA; Kuanhui Lee, MAAA, ASA; Raymond Len, MAAA, FCA, FSA; Timothy Luedtke, MAAA, FSA; Scott Mack, MAAA, ASA; Barbara Niehus, MAAA, FSA; Donna Novak, MAAA, ASA, FCA; Jason Nowakowski, MAAA, FSA; James O'Connor, MAAA, FSA; Bernard Rabinowitz, MAAA, FSA, FIA, FCIA, CERA; David Shea, MAAA, FSA; Steele Stewart, MAAA, FSA; Martha Stubbs, MAAA, ASA; Karin Swenson-Moore, MAAA, FSA; David Tuomala, MAAA, FSA, FCA; Rod Turner, MAAA, FSA; Cori Uccello, MAAA, FSA, FCA; Dianna Welch, MAAA, FSA, FCA; and Tom Wildsmith, MAAA, FSA.

AMERICAN BENEFITS COUNCIL

February 7, 2017

*Submitted via e-mail*

Mr. Andrew Bremberg
Assistant to the President and
Director of the Domestic Policy Council
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

**Re: Employer Reporting Under the Patient Protection and Affordable Care Act**

Dear Mr. Bremberg:

The American Benefits Council ("Council") looks forward to working with you in your vitally important role in the Trump Administration. The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. We especially look forward to working with you to protect the employer-sponsored health coverage of over 177 million Americans.[1]

We write to thank you for the flexibility outlined in the Executive Order President Trump issued on January 20, 2017, and to bring to your attention certain requirements prescribed by the Patient Protection and Affordable Care Act ("ACA") as you work to reduce the regulatory burdens associated with the law.

Specifically, we urge the administration to take immediate steps to minimize certain ACA requirements that impose significant costs and complexity on purchasers of health insurance, including employers who provide health benefits to their workforce using self-insured plans. Such arrangements are principally sponsored by large employers. One purpose of self-insuring is to enable companies to provide consistent benefits to

[1] U.S. Department of the Census, Health Insurance Coverage in the United States: 2015 – Current Population Reports (September 2016), *Table 1: Coverage Numbers and Rates by Type of Health Insurance: 2013 to 2015*.

their employees who are living and working in multiple states across the country.

**BACKGROUND**

The ACA imposes a host of requirements on employers, including sections 6055 and 6056 of the Internal Revenue Code ("Code"), as added by the ACA, which require certain annual Internal Revenue Service (IRS) information reporting by employers relating to the health coverage the employer offers (or does not offer). To the extent that an employer is an "applicable large employer" for purposes of the employer shared responsibility provisions of Code Section 4980H (i.e., "employer mandate"), Code Section 6056 prescribes reporting requirements, including details regarding whether the coverage meets the standards of "minimum essential coverage," "affordability," and "minimum value." Code Section 6055 requires all providers of "minimum essential coverage," including employer sponsors of self-insured health plans, to create reports describing the coverage provided to individuals. The purpose of Code Section 6055 is to help enforce the ACA's "individual mandate."

The employer mandate provisions set forth in Section 4980H impose a penalty on applicable large employers that fail to offer coverage to their full-time employees (and their dependents) under an eligible employer-sponsored plan. Section 5000A, the individual mandate, provides for a different penalty on certain individuals who do not maintain health coverage. Notably, to the extent an employee is enrolled in employer-sponsored coverage that qualifies as "minimum essential coverage" or is otherwise offered certain Code Section 4980H-qualifying coverage by his/her employer, this makes them ineligible for federal premium tax credits and cost-sharing reductions.

**ACA REPORTING REQUIREMENTS ARE SIGNIFICANTLY BURDENSOME**

The IRS published Forms 1094-B, 1095-B, 1094-C, and 1095-C to collect the information related to sections 6055 and 6066, to enforce the individual and employer mandates, and to assist in making sure that ineligible individuals do not receive a premium tax credit (as defined in Code Section 36B) to help pay for individual health insurance coverage. These reporting requirements generally went into effect for most employers for the 2015 tax year.

The stringent requirements of the employer mandate, and the compliance associated with reporting obligations implemented and enforced by the IRS, have been difficult and costly for employers. Today, employers continue to incur substantial expense in meeting their reporting obligations. This is, in part, due to the complexity of the forms that need to be provided to employees and filed with the IRS, as well as the need to modify benefit and payroll systems and to coordinate with third party record keepers and tax return preparers. Employers have also had to engage in significant training of human resources, benefits, and tax personnel and to implement changes to existing

recordkeeping practice and procedures for no reason other than to meet the information reporting obligations.

## ADMINISTRATIVE RELIEF IS NEEDED TO REDUCE REGULATORY BURDENS

It is imperative that Congress either fully repeal the employer mandate or reduce to zero dollars any penalties associated with the employer mandate. The Council is also urging the repeal of all associated employer reporting obligations.

To the extent employer reporting requirements are not repealed simultaneously with repeal of the employer mandate, it is vital that Congress ensure that any reporting requirements that continue are as minimally burdensome as possible. Simply put, in the absence of the ACA framework, there is no reason to retain complex and costly requirements that are specifically designed to implement that law.

In the interim, and in light of anticipated legislative "repeal and replace" of the ACA, the Council requests the Domestic Policy Council, and all appropriate executive branch agencies, use their authority and all the tools at their disposal, including those outlined in the Executive Order, to minimize the current burdens of ACA employer reporting. Specifically, we request relief (including, for example, through the issuance of a limited non-enforcement safe harbor) from any obligations or penalties related to tax years 2015-2017 (and, as applicable, later tax years), including:

(1) The employer shared responsibility provisions under Code Section 4980H;

(2) The information reporting requirements applicable to insurers, self-insuring employers, and certain other providers of health coverage under Code Section 6055; and

(3) The information reporting requirements applicable to large employers under Code Section 6056.

The Council notes there is established and recent precedent for such relief, which was provided by the IRS for calendar year 2014. See IRS Notice 2013- 45 (announcing delay in enforcement of Code Section 4980H and allowing for voluntary information reporting under Code sections 6055 and 6056 for 2014 to allow stakeholders adequate time to adjust to new law).

To the extent the administration believes it is necessary to continue with some form of information reporting during this interim period, insurers, employers, and other providers of health coverage should be permitted to voluntarily comply with the information reporting provisions. (We note that this also would be consistent with the approach set forth in Notice 2013-45 with regard to the year 2014.) **However, under no**

**circumstances should any penalties be applied for failure to comply with the information reporting provisions with respect to calendar years 2015, 2016 and 2017.**

Very importantly, reducing the reporting burden on employers will not have a negative impact on individual taxpayers. It seems likely that eligibility for the tax credit (both the existing tax credit and any potential new tax credit) will depend in part on an individual's access to employer-sponsored health coverage. In the past, the IRS has permitted individuals to rely on information provided to them by their employers to determine their eligibility for a premium tax credit without necessarily requiring a Form 1095-C. See, for example, IRS Notice 2016-4 ("[I]ndividuals who rely upon other information received from employers about their offers of coverage for purposes of determining eligibility for the premium tax credit when filing their income tax returns need not amend their returns..."). Such relief could be applied for calendar years 2016 and 2017 as well.

* * *

Employers have worked diligently since the 2010 enactment of the ACA to comply with the myriad of new taxes, fees, mandates, and reporting requirements imposed upon them and the employee health benefit plans they sponsor. In doing so, many employers have expended substantial resources in hours and dollars. **This administration has the opportunity to take action to help reduce the excess burdens imposed by the ACA's reporting requirements (Code sections 6055 and 6056) and the employer mandate (Code Section 4980H).**

We urge you to take action as soon as possible, thus allowing employers to reallocate resources to providing benefits to their employees and operating their businesses.

Thank you for considering our views. If you have any questions or would like to discuss these comments further, please contact us.

Sincerely,

James A. Klein

James A. Klein
President

CC: Acting Secretary Szubin, Department of the Treasury
John A. Koskinen, Commissioner, Internal Revenue Service

# Minnesota House of Representatives

September 26, 2017

The Honorable Thomas E. Price, M.D.
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Price,

We, as members of the Minnesota House of Representatives, write today to express our disappointment with your decision to reduce funding for Minnesota's Basic Health plan (BHP), MinnesotaCare. Your recent approval of a 1332 waiver for Minnesota is not the waiver we requested to implement our state's reinsurance program. We requested that the waiver hold Minnesota's BHP harmless. We had assurances from your agency and other federal agencies that our waiver would be approved with no reductions in funding for our BHP. Democrats and Republicans alike share the goal of stabilizing the private health insurance market, but we cannot do so in a way which jeopardizes the availability of quality health care for Minnesotans or that furthers cost shifting to others in the insurance market.

We were alarmed to hear that Minnesota's BHP funding would be reduced by $369 million. Worse, in the waiver, Minnesota is only set to receive $208 million for our reinsurance program, funds Minnesotans would have received in the form of tax credits without the waiver; this math simply does not make sense for Minnesotans.

We look at health care through a lens of innovation, from our robust medical device industry to lifesaving research at institutions such as the Mayo Clinic and University of Minnesota. We value having a healthy population, as evidenced by our second-lowest uninsured rate in the nation and our high rankings on many health measures.

Our BHP, created with bipartisan support, provided health insurance to working Minnesotans for over 25 years. Hundreds of thousands of Minnesotans, farmers, small business owners, young adults, and single parents, have used it to provide their families with affordable health care. Under the plan, Minnesotans, many of whom live in rural areas, have access to high-quality providers. Cutbacks to our BHP will result in increased uninsured rates and the transfer of costs, such as expensive emergency room utilization and delayed diagnoses, to others in the insurance market.

It's disappointing that our state is facing a brutal cut when your administration has called upon states to create their own innovative ideas to our nation's health care challenges. MinnesotaCare

was a solution developed over two decades ago that works for Minnesota. This is the kind of innovation your agency should be encouraging. Instead, your action of cutting our BHP funding goes in the opposite direction. We cannot fathom why your agency insists on moving us in a direction in which fewer Minnesotans would be insured and insurance costs would rise.

The reinsurance proposal is expensive to the state and a short term response to a market reeling under uncertainty. Reinsurance is a large subsidy to insurers with little accountability to the public, but it's what our state legislature approved and what our Governor allowed to become law. It's unconscionable that your agency would not only drag your feet in approving our waiver, but penalize Minnesota so harshly. We call on you to reverse your action devastating our state's BHP. Time is running out as the 2018 premium rates need to be finalized soon for public posting on October 2. It's time for you to live up to your responsibility in approving the waiver we requested, and to do so in a manner that does not jeopardize the rest of the health care market serving Minnesotans.

Sincerely,

Jennifer Schultz
State Representative

Erin Murphy
State Representative

Tina Liebling
State Representative

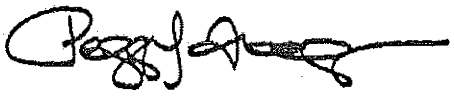
Laurie Halverson
State Representative

Diane Loeffler
State Representative

Jack Considine
State Representative

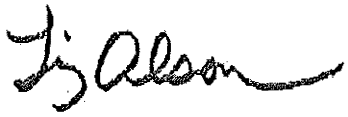
Dave Pinto
State Representative

Peter Fischer
State Representative



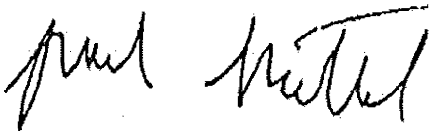
Peggy Flanagan
State Representative

Mike Freiberg
State Representative



Liz Olson
State Representative

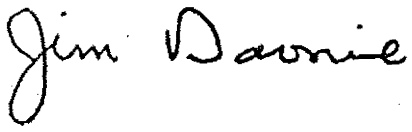
Linda Slocum
State Representative



Paul Rosenthal
State Representative

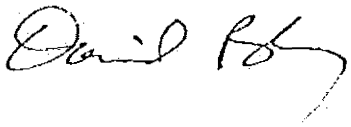
John Lesch
State Representative

Rob Ecklund
State Representative



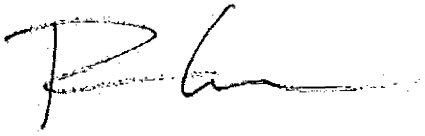
Jim Davnie
State Representative

Karen Clark
State Representative

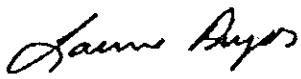


David Bly
State Representative

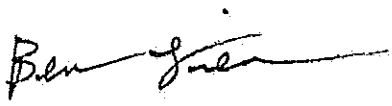
Duane Sauke
State Representative



Raymond Dehn
State Representative



Laurie Pryor
State Representative



Ben Lien
State Representative

Lyndon Carlson
State Representative

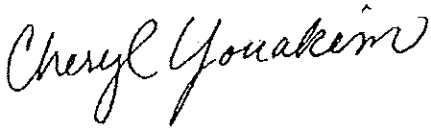
Michael Nelson
State Representative

Frank Hornstein
State Representative

Paul Thissen
State Representative

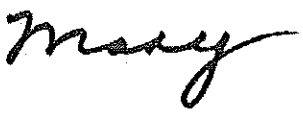
Rick Hansen
State Representative

Alice Hausman
State Representative

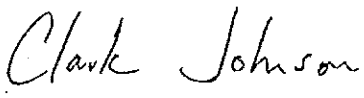


Cheryl Youakim
State Representative

JoAnn Ward
State Representative



Mary Murphy
State Representative



Clark Johnson
State Representative

Erin Maye Quade
State Representative

Fue Lee
State Representative

Julie Sandstede
State Representative

Connie Bernardy
State Representative

Sandra Masin
State Representative

CC: The Honorable Steve Mnuchin, Secretary of the Treasury
The Honorable Mick Mulvaney, Director of the Office of Management and Budget

J. Mario Molina, MD
CEO and Chairman

April 14, 2017

The Honorable Donald J. Trump
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20050

Dear Mr. President:

In 1980, Molina Healthcare, Inc. ("Molina") was founded to provide quality health services to financially vulnerable families and individuals. We entered the Health Insurance Marketplaces in 2014 with the goal of seamlessly covering our members as changes in eligibility moved them between coverage programs. We remain committed to this goal and to providing access to quality, affordable coverage if Congress and the Administration take important steps to stabilize the Marketplace for 2017 and beyond.

The first and most urgent and critical issue to maintaining stability of the Marketplace is the **continued funding for cost sharing reductions (CSRs).**

Cost-sharing subsidies have been essential for making coverage affordable for many members. Sixty-five percent of Molina Marketplace members are enrolled in plans with cost sharing subsidies. Removing them will make coverage unaffordable, likely causing them to drop insurance coverage and leave the Marketplaces, which in turn would undermine the risk pool and drive up costs for all consumers.

Molina is currently evaluating its 2018 participation in the Marketplace, and continued funding for CSRs is a critical determining factor in our decision to participate beyond 2017. As several states have filing deadlines in May, a funding solution must be found immediately.

We urge Congress and the Administration to act quickly to ensure CSRs are funded for the remainder of 2017 and also for 2018. We look forward to continuing to work with you to provide comprehensive, affordable Marketplace coverage to consumers.

Sincerely,

Joseph M Molina MD

J. Mario Molina, M.D.
CEO and Chairman

cc: The Honorable Thomas E. Price, M.D., Secretary of Health and Human Services
The Honorable Steven T. Mnuchin, Secretary of the Treasury
The Honorable Mick Mulvaney, Director of the Office of Management and Budget
The Honorable Seema Verma, Administrator, Centers for Medicare & Medicaid Services

Molina Healthcare, Inc. • 200 Oceangate, Suite 100, Long Beach, CA 90802
562-435-3666 • Fax: 562-951-1505

September 29, 2017

The Honorable Steven Mnuchin, Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Thomas E. Price, M.D., Secretary
United States Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: **Oklahoma 1332 Waiver Withdrawal**

Dear Secretaries,

Encouraged by federal communication to Governors promoting the use of 1332 State Innovation Waivers to provide individual health insurance market stability, Oklahoma invested significant resources in enacting legislation, establishing a state-operated reinsurance program and preparing a waiver with the required actuarial analysis. Waiver approval would have helped more than 130,000 Oklahomans' who today are struggling with dramatic price increases, provided greater than a 30% premium reduction and allowed nearly 30,000 individuals to buy insurance in a market many of whom were forced to leave because premiums are unaffordable.

After months of development, negotiation, and near daily communication over the past six weeks, the State and your departments agreed that waiver approval must be received no later than September 25, 2017. As late as last Friday, September 22nd, an agreed upon approval package had been circulated with the state expectation, and federal department promise, that waiver approval would be forthcoming on Monday, September 25th. When your departments communicated on Monday that waiver approval would not be provided, with no reason for the delay or timeframe for approval, the Oklahoma reinsurance program was effectively inoperative for the 2018 plan year. Three days later, beyond health plan commitment and rate filing deadlines, Oklahoma is forced to withdraw our waiver request due to failure of the Departments to provide timely waiver approval.

This withdrawal aims to provide clear direction to Oklahoma's insurance markets that for plan year 2018 there will be no market effects of Oklahoma's 1332 waiver proposal. Oklahoma must receive timely waiver approval and determination of federal pass through in order to provide adequate timeframes for consumer notices and issuer rate adjustments. Our State will continue to explore and develop 1332 waiver(s) for future consideration by your departments but request clear timeframes to navigate the federal waiver approval process.

While we appreciate the work of your staff, the lack of timely waiver approval will prevent thousands of Oklahomans from realizing the benefits of significantly lower insurance premiums in 2018.

Respectfully,

Terry Cline, Ph.D.

Terry Cline, Ph.D.
Secretary of Health and Human Services
Commissioner of Health
Oklahoma State Department of Health

**Draft Questions for: Redeem, Repair or Replace? Health Policy and the Tax System in 2017 and Beyond**

1. What key lessons should we take away from the ACA experience to date? What's working, what's not, and how should it be improved? (All, about 5 minutes each, starting with Jim, then Matt, then Heather.)

2. The ACA included income-based subsidies and penalties to encourage enrollment. The AHCA relies more on subsidies that vary by age. What is the best way to address adverse selection? (Matt to start)

    a. How much of a subsidy is needed to get young, healthy individuals to buy insurance in large enough numbers to stabilize markets?

    b. Is there a cheaper way to get a sustainable risk pool?

    c. How much funding is needed to make reinsurance/high risk pools work?

    d. Are there some markets, e.g., rural areas, where tax credits set for the national level just won't be enough? What if anything should the federal government do about that?

3. The ACA provided for some State flexibility through section 1332 waivers; current iterations of the AHCA provide a lot more. What are the opportunities and pitfalls here? (Heather to start)

    a. Should plans that don't cover EHBs or meet some minimal standards be subsidized through tax credits?

    b. How much discretion should the Administration have to approve or deny waivers? What conditions should state plans meet?

4. What market reforms or subsidy changes would empower consumers to make good health insurance plan and health care decisions? (Jim to start)

    a. How do we create sustainable risk pools and protect vulnerable populations like those with pre-existing conditions without stifling provider innovation and consumer choice?

    b. What role have HSAs played to date in empowering consumers? What role should they play?

5. Is wasteful health spending a problem? If so, what's the best way to control it? (All)

6. Audience questions (30 minutes)

| | |
|---|---|
| **From:** | Neis, Robert |
| **To:** | Johnson, Kathryn; Weiser, Carol; McCubbin, Janet; Leonard, Shelley |
| **Cc:** | West, Thomas; Vallabhaneni, Krishna |
| **Subject:** | FW: Employer Reporting Requirements -- letter from the National Coalition on Benefits |
| **Date:** | Monday, January 30, 2017 12:16:10 PM |
| **Attachments:** | image001.gif<br>image002.gif<br>image003.gif<br>NCB Employer Reporting Relief Letter to Trump Administration 1 30 17 FINAL.pdf |

FYI. Please forward as appropriate.

**From:** Katy Spangler [mailto:KSpangler@abcstaff.org]
**Sent:** Monday, January 30, 2017 12:06 PM
**To:** Neis, Robert; carolyn.a.tavenner@irs.gov
**Cc:** 'Janet Boyd (jcboyd@dow.com)'; Kathryn Wilber
**Subject:** Employer Reporting Requirements -- letter from the National Coalition on Benefits

Hi Rob and Carolyn:

We hope you are both well. The National Coalition on Benefits sent the attached letter to the White House Domestic Policy Council this morning and we wanted to ensure you both have a copy. If there are other colleagues at Treasury or IRS to whom we should send the letter, please let us know. Additionally, please feel free to share this with colleagues.

As mentioned in the letter, we would love to work with you to lessen the employer reporting requirements – especially in advance of the March 2, 2017 and March 31, 2017, furnishing and filing deadlines.

Please let us know if it would be helpful to discuss further.

Warm regards,

Katy

Katy Spangler
Senior Vice President, Health Policy
American Benefits Council
1501 M Street NW, Suite 600
Washington, DC 20005
202-621-1977 Direct
202-510-1889 Cell
kspangler@abcstaff.org

**Follow the Council**

recipient, please advise by return e-mail and delete immediately the email (and any attachment) without reading or forwarding to others.

**From:** Charlotte Ivancic
**To:** Kowalski, Daniel
**Subject:** Meeting request for Wednesday, April 26th
**Date:** Wednesday, April 19, 2017 3:18:32 PM

---

Dan -- Thanks for agreeing to meet with us on Wednesday, April 26th at 11:15am. There will likely be 6 of us in total -- including myself and Bobby Garcia, the CEO of Triple-S, the Blue Cross Blue Shield plan of Puerto Rico. We will also likely have with us 4 additional senior executives from other Puerto Rican health insurance plans. We will plan to discuss our position that the ACAs health insurance tax should not be applied to Puerto Rican health plans since the law otherwise does not apply in Puerto Rico (no individual mandate or subsidies and no exchange). Thanks and see you then!

**From:** McCubbin, Janet
**To:** "burman, len"; "jcapretta@aei.org"; "Matthew Fiedler"; "HeatherH@princeton.edu"
**Subject:** RE: National Tax Association Spring Symposium
**Date:** Friday, April 28, 2017 7:04:00 PM
**Attachments:** Draft NTA Health Reform Questions.docx

---

Thanks everyone for the call today. Here are a few notes to recap, and to fill Jim in.

We agreed to use the attached outline as a guide but deviate if the conversation is taking us in other interesting directions. We want the session to be interactive between the panelists and (a bit farther in), between the panel and the audience.

We agreed to start with a general "lessons learned" question, but will try to keep the responses to 5 minutes each. We will start with Jim, and then Matt and then Heather for Q1 responses.

Len suggested that we raise the issue of whether the ESI exclusion should be eliminated so that the subsidy is the same – a credit – regardless of whether insurance is obtained through the employer or non-group market. We agreed that was a good question, though it is probably not on the table for upcoming legislation. Matt suggested that it could be worked into #2 or #4.

Len suggested that we talk about the taxes that are in the ACA (since this is a tax conference). I agreed to prepare a question that I can ask of Len, in the audience Q&A. (Alternatively, Len, you could just use your prerogative as moderator to make the point when it seems appropriate.)

We would like to talk about containing costs (#5), but not at the expense of getting to audience questions. Perhaps #4 will cover much of what we might say in #5. Or we can take some audience questions and then get back to #5.

No one is planning to use slides or handouts. (But let me know if you change your mind(s).)

One item I forgot to mention – I will provide a brief introduction to start. Or Len could do it…but then Len will have to introduce himself. Len, let me know what you prefer.

Please let me know if you have other thoughts or questions.

Thanks again – this is really going to be a great discussion.

-----Original Appointment-----
**From:** McCubbin, Janet
**Sent:** Tuesday, April 18, 2017 1:52 PM
**To:** McCubbin, Janet; 'burman, len'; 'jcapretta@aei.org'; 'Matthew Fiedler'; HeatherH@princeton.edu; acleven@urban.org
**Cc:** 'dsacke@princeton.edu'
**Subject:** National Tax Association Spring Symposium
**When:** Friday, April 28, 2017 3:30 PM-4:30 PM (UTC-05:00) Eastern Time (US & Canada).
**Where:** 202-927-2255, PIN 183110

Thank you everyone. We are confirmed for 3:30 on April 28th.

Phone: (b) (6)

PIN (b) (6)

---

**From:** McCubbin, Janet
**Sent:** Tuesday, April 18, 2017 9:22 AM
**To:** 'burman, len'; 'jcapretta@aei.org'; 'Matthew Fiedler'
**Cc:** 'dsacke@princeton.edu'
**Subject:** RE: National Tax Association Spring Symposium

Good morning everyone.

It appears that April 27th will not work. Are you available 2:30 or later on Friday April 28th?

Thanks again, Janet

**From:** McCubbin, Janet
**Sent:** Thursday, April 13, 2017 11:59 AM
**To:** 'burman, len'; 'jcapretta@aei.org'; 'Matthew Fiedler'; 'HeatherH@princeton.edu'
**Subject:** National Tax Association Spring Symposium

All,

Thank you for agreeing to participate in a panel discussion on health reform at the National Tax Association Spring Symposium, at 10:45am on May 18 in Washington DC. Registration information and a preliminary program may be found in the attached.

I would like to organize a preparatory call to provide our moderator, Len Burman, with suggested questions for the panel and ensure we have a coherent discussion. I am thinking that each of you will be asked at least one question that tees up an opportunity for you to provide your overall views at some length, that Len and all of you will be given time to ask questions and engage in a back and forth, and then we will open it up to questions from the audience. If you would like to send me questions in advance of our prep call, I will be happy to compile and circulate them to the panel.

Would some time on April 27th or thereabouts work for a call? Please feel free to let me know if other days work better for you, as we have plenty of time to coordinate.

Thank you again for participating in the panel. You are going to be a highlight of the program!

Janet

NATIONAL COALITION
ON BENEFITS

January 30, 2017

*Submitted via email*

Andrew Bremberg
Assistant to the President and
Director of the Domestic Policy Council
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

**Re: Employer Reporting Under the Affordable Care Act**

Dear Mr. Bremberg:

Congratulations and thank you for serving our nation as part of the new Trump Administration. The National Coalition on Benefits ("Coalition") looks forward to working with you.

The Coalition is comprised of industry trade associations representing large and small businesses, as well as employers with operations and employees in all 50 states. The Coalition has been a long-time supporter of ensuring all Americans have access to affordable health insurance coverage. More than 177 million Americans currently enjoy employer-sponsored health coverage, and we urge you to protect this important benefit as you work to repeal and replace the *Patient Protection and Affordable Care Act* ("ACA").

We greatly appreciate the flexible approach outlined in President Trump's Executive Order, issued on January 20, 2017, which instructed federal agencies to minimize the economic burdens of the ACA for a range of stakeholders, including purchasers of health insurance. This would include employers who provide health benefits to employees using insurance and self-insured arrangements.

This letter focuses exclusively on the issue of the employer mandate and the accompanying employer reporting requirements, given the immediate and

burdensome deadlines of March 2, 2017, and March 31, 2017. We also look forward to working with the Trump Administration to ensure the ability of employers to offer uniform coverage across all 50 states is maintained and strengthened and the tax-treatment of health care is beneficial for employees and employers alike.

Under the ACA, employers over a certain size face an excise tax if they do not offer certain qualifying coverage to employees who work an average of 30 or more hours per week (the "employer mandate"). They must also collect copious amounts of information and complete forms that must be provided to their employees and filed with the Internal Revenue Service (IRS) on an annual basis. Under the law, employers that do not offer such qualifying coverage or are unable to file or furnish the IRS forms run the risk of incurring significant penalties.

The stringent requirements imposed on employers by the associated reporting obligations have been, and will continue to be, very difficult and costly for employers. We urge you to act in accordance with the Executive Order to "exercise all discretion and authority available to waive, defer, grant exemptions from, or delay the implementation of any requirement of the Act" by taking immediate steps to ease the burdens imposed on employers by the ACA's mandatory reporting obligations.

We conclude by asking that you use the full authority vested in the Executive Branch to relieve employers of the burdens imposed on them by the ACA. We look forward to working with you to continue providing working Americans and their families with access to quality employer-sponsored health coverage, while easing the economic and regulatory burdens imposed on employers by the ACA.

Thank you for considering our views on this matter. If you have any questions or would like to discuss these comments further, please contact us.

Sincerely,

The National Coalition on Benefits

CC: Acting Secretary Szubin, Department of the Treasury
Commissioner Koskinen, Internal Revenue Service
Individual Members of Congress

MINNESOTA COUNCIL of HEALTH PLANS

COURT INTERNATIONAL BUILDING
2550 UNIVERSITY AVENUE WEST
SUITE 255 SOUTH
ST. PAUL, MINNESOTA 55114
651-645-0099 FAX 651-645-0098

October 9, 2017

The Honorable Don Wright
Acting Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

The Honorable Steven Mnuchin
Secretary of the Treasury
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20500

Dear Acting Secretary Wright and Secretary Mnuchin,

More than 100,000 working, poor Minnesotans rely on MinnesotaCare, our state's Basic Health Plan, to get the medical care they need. Recent decisions by the federal government put MinnesotaCare's future funding at risk.

Echoing the statements of others across out state, my organization, along with our member health insurers, join community organizations and elected officials in asking you to reconsider the decision that reduces MinnesotaCare funding with the approval of our state's 1332 reinsurance program waiver. These programs are both essential components of our state's strategic work to help ensure Minnesotans get care. MinnesotaCare is a valuable pathway between Medicaid and private insurance, easing transitions and helping ensure consistent care for individuals and families.

Throughout the development and negotiation of the state's 1332 waiver application, there was an expectation that MinnesotaCare funding would be maintained as is. We have been told the Centers for Medicare & Medicaid Services and the Department of Treasury assured the state the waiver application met all requirements to keep MinnesotaCare funding intact.

Minnesotans should not be punished for our innovative work that helps simplify the complex health care system so people get care. Our new state-based reinsurance program and decades old MinnesotaCare reflect this commitment to innovation. We respectfully request you support this important work by maintaining the MinnesotaCare BHP funding in the 1332 reinsurance waiver approval.

The problem of rising medical bills is too complex to address without strong partnerships. We believe that our waiver can lower the cost of insurance and we are asking you to support it in partnership with the State, its insurers, and the many Minnesotans that buy insurance on their own.

Sincerely,

James Schowalter
President & CEO

Blue Cross and Blue Shield/Blue Plus of Minnesota ■ HealthPartners ■ Hennepin Health
Medica ■ PreferredOne ■ Sanford Health Plan of Minnesota ■ UCare

CC:
Seema Verma, Administrator, Centers for Medicare and Medicaid Services
Senator Al Franken
Senator Amy Klobuchar
Representative Tim Walz
Representative Jason Lewis
Representative Erik Paulsen
Representative Betty McCollum
Representative Keith Ellison
Representative Tom Emmer
Representative Collin Peterson
Representative Rick Nolan
Governor Mark Dayton
Commissioner Emily Piper, Minnesota Department of Human Services
Speaker of the House Kurt Daudt
State Senate Majority Leader Paul E. Gazelka
State Senator Thomas M. Bakk, Minority Leader
State Representative Melissa Hortman, Minority Leader
State Senator Gary H. Dahms
State Representative Greg Davids